S. Hrg. 101-414

INDIAN MENTAL HEALTH DEMONSTRATION GRANT PROGRAM

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

S. 1270

TO PROVIDE AN INDIAN MENTAL HEALTH DEMONSTRATION GRANT PROGRAM

SEPTEMBER 14, 1989
WASHINGTON, DC

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INDIAN MENTAL HEALTH DEMONSTRATION GRANT PROGRAM

THURSDAY, SEPTEMBER 14, 1989

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 2 p.m., in room 485, Russell Senate Office Building, Hon. John McCain (vice chairman of the committee) presiding.

Present: Senators McCain, Murkowski, Conrad, Gorton, and Cochran.

STATEMENT OF HON. JOHN McCAIN, U.S. SENATOR FROM ARIZONA, VICE CHAIRMAN, SELECT COMMITTEE ON INDIAN AFFAIRS

Senator McCAIN. The Select Committee on Indian Affairs will come to order.

The purpose of this hearing is to consider S. 1270, a bill to provide an Indian mental health demonstration grant program.

Ladies and gentlemen, I appreciate your joining me and the other members of this committee this afternoon for a discussion of something which poses a serious threat to the health status and lives of Native Americans, Native Alaskans, and Native Hawaiians—that is mental health. During this hearing we will be discussing S. 1270, legislation to provide an Indian mental health demonstration grant program. I appreciate the support of Senators Murkowski, DeConcini, Cochran, and Daschle, who have joined me as cosponsors of this legislation, which was introduced on June 23.

As we all know, Native Americans have the lowest health status of any population group in our country. I might say, however, that the Indian Health Service, under the direction of Dr. Rhoades, his predecessor Dr. Johnson, and others, has certainly done much and has had many successes in dealing with the threat that many common diseases and maladies used to pose to the lives of Native Americans. However, mental health is among the remaining serious threats to the lives of Native Americans.

I am hopeful that this hearing will set the stage for more effectively dealing with the mental health needs of Native Americans. I hope we will come away knowing more about the mental health problems, what is currently being done to deal with these problems, and some of the innovative ideas that individuals and tribal communities have to address these problems.

[Text of S. 1270 follows:]

101ST CONGRESS
1ST SESSION

S. 1270

To provide an Indian mental health demonstration grant program.

IN THE SENATE OF THE UNITED STATES

JUNE 23 (legislative day, JANUARY 3), 1989

Mr. MCCAIN (for himself, Mr. MURKOWSKI, and Mr. DECONCINI) introduced the following bill; which was read twice and referred to the Select Committee on Indian Affairs

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A BILL

To provide an Indian mental health demonstration grant program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

GRANT PROGRAM

SECTION 1. Title II of the Indian Health Care Improvement Act (25 U.S.C. 1601, et seq.) is amended by adding at the end thereof the following new section:

"MENTAL HEALTH DEMONSTRATION GRANTS

"SEC. 209. (a)(1) The Secretary, acting through the Service, shall award at least 10 demonstration grants to Indian tribes or inter-tribal consortia to pay 75 percent of the costs of planning, developing, and implementing programs provided by the Indian tribes or inter-tribal consortia that deliver mental health services to Indians through innovative and community-based means.

"(2) Any grant awarded under paragraph (1) shall not exceed $1,000,000 for each fiscal year.

"(3) For purposes of this section, the term 'inter-tribal consortium' means a partnership between—

"(A) an Indian tribe or a tribal organization of an Indian tribe, and

"(B) one or more other Indian tribes or tribal organizations of other Indian tribes.

"(b)(1) The term of any grant awarded under subsection (a) shall be 3 years.

"(2) In awarding at least 50 percent of the total number of grants awarded under subsection (a), the Secretary shall provide a preference to inter-tribal consortia.

"(3) The 25 percent of the costs of planning, developing, and implementing a program for which a grant is awarded under subsection (a) that are not to be paid from such grant may be paid by the grant recipient in cash or through the provision of property or services.

"(4) The mental health services delivered under any program that is funded by a grant awarded under subsection (a) may include alcohol and drug abuse treatment.

"(c)(1) Any Indian tribe or inter-tribal consortium may submit to the area office an application for a grant under subsection (a).

"(2) Any application submitted under paragraph (1)—

"(A) shall be in such form as the Secretary may prescribe,

"(B) shall be submitted to the area office before a date designated by the Secretary,

"(C) shall specify—

"(i) the nature of the program proposed by the applicant,

"(ii) the data and information on which the program is based,

"(iii) the extent to which the program plans to use or incorporate existing service delivery activities,

"(iv) the specific treatment concepts to be used under the program,

"(v) the extent of the planned use under the program of the traditional clinical model, and

"(vi) a schedule (of not more than 3 years) for completion of the program, and

"(D) shall be accompanied by a statement from the various Indian populations and Indian-related service-delivery systems in the vicinity of the applicant that would be affected by the program.

"(3) The area office to which an application is submitted under paragraph (1) shall attach to the application the comments of the area office regarding the application and shall forward the application to the Secretary.

"(d) The Secretary shall award grants under subsection (a) in accordance with regulations the Secretary shall prescribe. Such regulations shall ensure that the Secretary take into account, among other considerations—

"(1) any comments from an area office with respect to an application,

"(2) any comments of the Indian communities that would be affected by the program for which the application is submitted,

"(3) the existing mental health services currently available to the Indians the program proposes to serve,

"(4) the need for mental health services among the Indians the program proposes to serve, as described by the Indian tribe itself and the appropriate area office,

"(5) the extent to which the program would improve the access of Indians to mental health services,

"(6) the extent to which, and the manner in which, the program would improve the effectiveness of mental health service delivery in the area served by the program, and

"(7) the extent to which the program would provide Indians with access to a mental health service delivery system that effectively combines the modern clinical approach with the particular customs or culturally based methods of Indian tribes in treating members of the Indian tribe.

"(e)(1) Each recipient of a grant awarded under subsection (a) shall—

"(A) furnish the Secretary with such information as the Secretary may require to—

"(i) evaluate the program for which the grant is made, and

"(ii) ensure that the grant funds are expended for the purposes for which the grant was made, and

"(B) submit to the Secretary at the close of the term of the grant a final report which, in addition to such other information as the Secretary may require, includes—

"(i) an assessment of the extent of the mental health needs of the Indians served by the program,

"(ii) the details of the program,

"(iii) the problems encountered in establishing the program,

"(iv) the extent to which the program was effective or ineffective in meeting the mental health needs of Indians, and

"(v) any recommendations of the grant recipient.

"(2) On the date that is 18 months after the date on which most of the grants are awarded under subsection (a), the Secretary shall submit to the Congress a preliminary report which shall—

"(A) assess the functioning and status of the grants,

"(B) evaluate the progress made toward achieving the purposes of the grants, and

"(C) include any recommendations the Secretary may deem appropriate with respect to the grants.

In preparing the preliminary report, the Secretary shall solicit and include the comments and recommendations of private and public entities with an interest in the delivery of mental health services to Indians.

"(3) By no later than the date that is 180 days after the close of the term of the last grant awarded under subsection (a), the Secretary shall submit to the Congress a final report on the grants awarded under subsection (a) which shall include conclusions on the grants, as well as comments on the implications of the demonstration grants for possible re-organization of mental health service delivery in Indian country.

"(f) There are authorized to be appropriated to carry out the provisions of this section, $6,000,000 for each of the fiscal years 1990, 1991, 1992, and 1993.".

TECHNICAL ASSISTANCE SECTION

SEC. 2. (a) The Secretary of Health and Human Services shall establish within the Office of Research and Development of the Indian Health Service a technical assistance office on mental health that shall—

(1) act as an information center for Indian tribes and tribal organizations regarding on-going mental health activities, programs, and services within Indian country,

(2) provide technical assistance to Indian tribes, or inter-tribal consortia, that are working to implement programs under the demonstration grants provided under subsection (a),

(3) facilitate regional meetings to enable Indian tribes and tribal organizations to share information regarding—

(A) the mental health needs of Indian tribes,

(B) activities that are being undertaken to meet those needs, and

(C) programs that have been successful in meeting those needs,

(4) develop strategies that Indian tribes can take to meet the mental health needs of their members, and

(5) disseminate information regarding such strategies among the Indian tribes and tribal organizations.

(b) The Secretary of Health and Human Services shall provide the mental health technical assistance section that is required to be established under subsection (a) with such staff, facilities, and equipment as are necessary to enable the section to carry out the duties of the section.

(c) The mental health technical assistance section that is required to be established under subsection (a) shall terminate on the date that is 30 days after the date on which the final report is submitted to the Congress under section 209(e)(3) of the Indian Health Care Improvement Act.

Senator McCain. Today we will be hearing from a host of experts, mental health care providers, and representatives of Native American and Native Alaskan communities. Because I want this to be an interactive and learning process, I am going to forego the usual order of calling the witnesses in favor of what I hope will best facilitate the greatest amount of interaction possible.

The first panel today will consist of Ms. Mona Fernandez, Inter-Tribal Council of Arizona; Mr. Emory Johnson, representing the Cheyenne River Sioux Tribe; Ms. Jenny Rodgers, Acting Department Director of the Navajo Department of Health; Ms. Nell Rogers, Director, Office of Education and Health Planning; and Ms. Greta Holly, Executive Director of Vocational Rehabilitation Services of Mississippi Band of Choctaw Indians. Then Doctor Rhoades and Staff and Denise Dougherty of the OTA. Then we will conclude with another panel of Native Americans and health care providers.

Native Americans suffer from the highest rates of suicide, drug abuse, and alcoholism of any population group in this country. While other factors certainly play into this, I am told that mental health is often a factor. Yet, I would suggest that we do not currently focus enough attention or resources in this area. In fact, only about three percent of the IHS budget is dedicated to the area of mental health services. This is not to suggest, however, that the Indian Health Service is not doing a good job with what they have available, but there is always room for improvement. In my view, we need to give this issue higher priority.

As I began looking at this issue, I found several significant facts.

Not only can unaddressed mental health needs be the root cause of one's alcohol or drug abuse problem; it can also cause or lead to the exacerbation of an illness. Mental health problems, themselves, may actually be caused by the illness or the abuse of alcohol or drugs. What's more, left unaddressed, mental health problems can lead to the loss of life.

Of course, there are some who are chronically mentally ill. And there are some who develop mental health problems as a result of the activities perpetrated by others.

I recently spent a great deal of time as a member of the Special Investigations Committee looking at one example—the problem and effects of child sexual abuse in Indian country, one of the most heart-wrenching issues I've ever dealt with in my time in Congress.

To say that the destruction left in the wake of these people's deviant behavior is horrible is an understatement. It has left serious marks on the lives of these children, their families, and the communities in which they live. Left unaddressed, the effects could linger for generations to come.

Today we will be hearing from two tribes who have faced this issue in a very real way in the past couple of years.

We definitely need to take steps to diminish the chance of the situation these tribes faced from ever occurring again. And I might say that I am currently working hard to put together a legislative package to address this problem. In the meantime, however, the reality is that the Native American children who have been abused, and in some cases their families and communities, need assistance in dealing with the serious marks left on their mental health.

At least two different approaches could be taken to address the inadequacy of the mental health delivery system. One approach involves complete and massive reform of the existing system. Another approach takes deliberate, calculated steps to determine what works best, followed by comprehensive reform.

S. 1270 favors the more deliberate approach. It would add to the current base of services a small number of short-term demonstration projects. The program would serve as a tool to assist us in determining the most effective steps to take in expanding mental health services available to the Native American population. In doing so, it places the keys directly in the hands of Native Americans themselves.

Obviously, this legislation is only a starting point from which a full reform could be crafted.

This bill provides for at least 10 3-year grants, of no more than $1 million each, to be competitively awarded to Indian tribes and tribal communities. They will assist with the costs of planning, developing, and implementing programs.

One important aspect is that it will allow each tribe or consortia awarded a grant to design a program they believe will best address the mental health needs of their population. This will permit a combining of existing clinical approaches with traditional cultural approaches.

While, again, this is only an admitted first step, I believe it is necessary to approach the problem in this fashion. A great disservice could be done by moving headlong too quickly into a full-scale reform of the current system without either the experience of what works and/or the support of the Native American community—support built through assisting these communities as they develop real solutions. The ultimate solution rests with the individuals, families, and tribal communities.

I believe that the program proposed in this bill will provide us with all the information and experience necessary to develop an appropriate reform of the mental health services for Native Americans.

I look forward to hearing from all of the witnesses and appreciate your taking time from your busy schedules to contribute to this process and participate in this hearing.

I would like to conclude by mentioning the fact that I look forward to working with other members of the committee— especially the chairman, Senator Inouye, whose interest and commitment for health issues—and mental health issues, in particular—is well known.

I'd like to call the first panel: Ms. Mona Fernandez, the Inter-Tribal Council of Arizona; Doctor Emory Johnson; Ms. Jenny Rodgers; Ms. Nell Rogers; and Ms. Greta Holly. Please come forward.

Welcome. Please feel free to summarize your statements if you so choose. Your full statement will be made a part of the record.

Ms. Fernandez, please proceed.

STATEMENT OF MONA FERNANDEZ, INTER-TRIBAL COUNCIL OF ARIZONA, INC.

Ms. **Fernandez**. First of all I'd like to say good morning to the committee and staff and introduce myself. My name is Mona Fernandez. I'm the Tribal Council Treasurer for the Colorado River Indian Tribes. This morning I am speaking on behalf of the Inter Tribal Council of Arizona.

The Inter Tribal Council of Arizona is an organization of 19 tribal governments. We appreciate the opportunity to express our support for S. 1270, the Mental Health Demonstration Grant program.

Senator McCain, in his introductory remarks of S. 1270, stated that the current mental health service delivery system is woefully inadequate to meet the needs of American Indian communities. This factual statement is substantiated by the following:

The ten bed psychiatric wing of the Gallup, New Mexico, Indian Health Service Hospital is the only IHS inpatient psychiatric care unit in the Nation.

Of the IHS budget, 1.2 percent is designated for mental health services.

In the Phoenix area, the Phoenix Indian Medical Center, a four-state medical referral facility, provides health care for more than 109,000 Indian people. During fiscal year 1988, the medical center had 103,730 outpatient visits and 5,857 admissions.

The Phoenix Indian Medical Center has one psychiatrist on staff to provide mental health services. It has been recommended that in order to provide adequate mental health services there should be at least one psychiatrist for every 25,000 people, one psychologist for every 5,000 people, and a medical social worker for each tribal community.

Tribal populations in Arizona have extremely high rates of suicide, alcohol and substance abuse. According to information from the Arizona State Department of Health Services/Department of Behavioral health Services plan, the median income of American Indian clients served in the DHS/DBHS system is approximately $2,500, and the unemployment rate is 83 percent.

The State of Arizona ranks 50th in the Nation in per capita mental health expenditures.

Only 5 of 20 tribal governments in Arizona have been able to access very limited State behavioral health resources through contracts.

The Phoenix Area Indian Health Service has not encouraged or assisted tribes to contract for mental health services. This factor, as well as the minimal funds available for mental health service provisions, makes it virtually impossible for tribes to administer programs. As a consequence, only 5 of 20 tribal governments in Arizona have contracted for services.

There is an urgent need for inpatient psychiatric care for Indian people. For several years, tribes in Arizona have tried to negotiate with the State of Arizona for involuntary inpatient psychiatric care for tribal members at the Arizona State Hospital. This problem has been ongoing, and although tribal and State representatives have met numerous times, no resolution has been reached. The result is that safety of tribal communities and the individual needing psychiatric care are at risk. Tribal access to State mental health facilities is long overdue and should be addressed in this legislative proposal.

Since the level of funding is inadequate to provide a quality level of mental health care, tribes have creatively combined resources so that limited services can be provided. Tribes do access funds to provide alcohol and drug services for their communities and they can determine the services that are to be provided with the funds. However, two major problems are that there is no clear equitable allocation process for distribution of funds, and for many tribes the amounts are very small.

IHS also has a small number of contracts with tribes, private counselors, and clinics for inpatient and outpatient alcohol and drug rehabilitation services. Presently there are only four small facilities in Arizona that contract with IHS to provide residential services to Indian people. These facilities are located in Sacaton, Parker, Phoenix, and White River.

The Colorado River Indian Tribes Alcohol and Drug Abuse Program in Parker operates a residential treatment facility which has a capacity for eight adult men.

The Indian Rehabilitation, Inc., located in Phoenix, operates a 16-bed facility for Indian men and a 12-bed facility for Indian women.

The White Mountain Apache Alcohol and Drug Abuse treatment facility located in White River operates a 10-bed facility of which 6 beds are for men and 4 beds are for women. The White Mountain Apache IHS hospital has a five-bed inpatient detoxification, stabilization, evaluation and referral program.

The Gila River Indian Community operates a 12-bed halfway house located in Sacaton for men and women. With the exception of one position funded by IHS, this program is supported entirely with tribal funds. The Colorado River Indian Tribes and the White Mountain Apache Tribe supplement the IHS money with tribal funds so that residential services can be provided. The Indian Rehabilitation program uses state funds, grants, and other donations combined with IHS monies to enable provision of services.

Involuntary inpatient psychiatric care is provided at Gallup, New Mexico IHS hospital. Additionally, IHS contracted with psychiatric hospitals to provide care to Indian people, but this is limited to ten days of hospitalization. Also, many of the contracting hospital staff and Indian patients experience cultural differences in relating to each other and, as a result, there are difficulties in treatment. Consequently, IHS has found that the hospitals are reluctant to renew contracts with IHS.

Mental health services for Indian people must be a priority. It is also critical, if services are to be successful, that the traditional clinical model be incorporated with treatment that is culture specific.

We applaud the recognition by Congress of the need to develop a more effective and comprehensive mental health delivery system for Indian people. We appreciate the efforts of Senators McCain and DeConcini to undertake this issue and to move forward by introducing this legislative proposal.

Arizona tribes know that major modifications are needed to increase financial support for mental health programs. Based on experience, Arizona tribes also know the type of treatment needed for successful intervention and prevention.

Given the existing lack of services and funds, there is an overwhelming need to appropriate funds, in addition to the demonstration projects, so that more effective and comprehensive mental health delivery systems will become a reality. Without a stable source of funds to develop, maintain, and expand tribal mental health programs, services for all Indian people will continue to be provided on an inconsistent crisis basis.

There are areas within the proposed legislation that we wish to address.

On page 2, line 14: Historically, the tribes have been viewed as government entities and, as such, the Federal Government has related to tribes on a government-to-government basis. The Indian Self-Determination Education and Assistance Act of 1975 further acknowledged the rights of tribes to manage and govern their own affairs.

Given these factors and knowing that each tribe is unique in needs and resources, we cannot support the concept of preference to inter-tribal consortia.

Already, tribes in Arizona work closely with one another in provision of services. There are tribes who find that it is cost effective to contract with another tribe for services and thereby eliminate some of the administrative costs and other costs associated with operating a project. All tribes deserve priority consideration.

On page 2, line 22: We support the inclusion of alcohol and drug abuse treatment as services that will be delivered under this program.

On page 3, line 23: We oppose this language and recommend that the coordinating mechanisms between tribes, IHS, and other Indian-related service delivery systems be described in the proposal application.

Page 4, line 11: With regard to the provision that, "Any comments from an area office with respect to an application", we recommend that tribes outline in the proposal application how coordination will occur with IHS.

Page 7, line 8: We question the establishment of another level of bureaucracy. There already exists within IHS an Office of Mental Health. The office, staffed at an inadequate level, has been established for a number of years. What is the purpose of the existing office and how will that office coordinate with the Office of Research and Development? Will there be duplicative efforts? What amount of funds will be used to support the Office of Research and Development? Where will these funds come from?

Regional meetings for the purpose of sharing information is important, but identifying and securing funds and services for tribes to solve issues and provide treatment services is a priority.

The Inter Tribal Council of Arizona strongly recommends that funds be targeted for prevention and treatment projects rather than to fund of Office of Research and Development.

We appreciate the opportunity to comment on S. 1270 and support your efforts in addressing the mental health needs of American Indians.

Thank you.

[Prepared statement of Ms. Fernandez appears in appendix.]

Senator McCAIN. Thank you very much.

I note the presence of several of my colleagues who I would like to call upon at this time if they have any statements or comments. Senator Murkowski.

Senator MURKOWSKI. Thank you very much, Mr. Chairman.

First of all, let me congratulate you. I think you have provided an excellent piece of legislation here. The problems that would be addressed by this bill will be enunciated by the witnesses, and I think your statement reflects a clear explanation of why the bill is needed.

I'd like to ask that a statement by the Alaska Native Health Board in support of S. 1270 be entered into the record.

Senator McCAIN. Without objection.

[Prepared statement of the Alaska Native Health Board appears in appendix.]

STATEMENT OF HON. FRANK H. MURKOWSKI, U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. I have a very brief statement, Mr. Chairman.

I am very pleased to be a cosponsor because I think your bill encourages tribes and Alaska Native villages to draw upon knowledge that they uniquely possess to propose innovative approaches to problems of mental health that affect their communities. I am also, of course, referring to drug and alcohol problems, as well.

I think your bill encourages the tribes and villages to integrate modern clinical practices with traditional values that the people that are in the areas know and understand and to plan for delivery of services that are practical in many of our rural remote locations.

At present, the opportunity for community-based efforts to obtain funding assistance has been severely limited. In the western Alaska village of St. Mary's, which our chairman visited last year, for instance, the people have sought for 2 years to obtain funding for a family centered program for dealing with alcohol and related problems. The Native Health Board has been seeking assistance to implement community self help efforts at combatting alcohol use and drug abuse in rural Alaska.

And I might remind you, Mr. Chairman, that currently our figures of suicide among male natives 24 years of age or younger is 14 times the annual rate—this is the annual national rate—and this relates primarily without exception to drug and alcohol abuse.

This particular program, as proposed by St. Mary's would potentially be covered under this bill as a competitive proposal, has the capability of not just taking in the individual afflicted person, whether he or she be afflicted with alcohol or drug abuse, but to bring in the family—and, in some cases, bring in a portion of the village. The value of that in the sophisticated treatment can't be underemphasized by any means.

Last year the State of Alaska inaugurated a grant program to assist Alaska Native villages in their search for ways to prevent suicide among our young Native population, and that program relies on the villages to determine what is to be done for their own individual needs. The program is also similar to your bill's intention in that public agencies provide technical assistance.

A State of Alaska representative is here today, Ms. Susan Soule, and is on your witness list today, Mr. Chairman. I want to thank you for extending an invitation to her. She has much experience in rural Alaska and is the coordinator of the program which I have mentioned.

I am going to be departing. I have a corresponding meeting in the Intelligence Committee. However, Mr. Bob Arnold, of course, will be here. Thank you for the opportunity to make my statement.

Senator McCain. I'd like to thank my colleague from Alaska for his commitment on this issue.

I did have the opportunity the summer before last of visiting Alaska. I visited several areas. In the meetings with the leaders, they obviously were appreciative of your efforts on their behalf. And they also stated that the number one problem that existed with them was alcohol abuse. When you're talking about the isolated villages, it was clear to me just from a short visit that the problem is one which cries out for some kind of solution. I appreciate your efforts on behalf of helping these people with that terrible curse of alcoholism.

Senator Murkowski. Thank you, Mr. Chairman. I would say that now drugs are synonymous with alcohol, unfortunately.

Senator McCain. Senator Conrad.

Senator Conrad. Thank you, Mr. Chairman.

I want to join in commending the Senator from Arizona for the initiative he has shown in putting together this proposal. I have not as yet joined as a cosponsor because there are a number of questions that I'd like to get answered as we go through this hearing today and possibly beyond. The questions that I have that I'd like to get answers for include, but are not limited to, the following: First of all, the source of the funds that would be used for this initiative; second, the effect on other programs—would other programs be required to take some reduction in order to fund this initiative?

A third area that I am interested in learning more about, Mr. Chairman, involves the geographic distribution of the health demonstration grants: is there any provision contemplated that would give us some assurance of a geographic distribution, given the fact that there are different conditions in different parts of the country, different problems being faced by the Indian people in different parts of the country? And therefore we'd be assured that we don't get a concentration of the grant in one part of the country or in parts of the country that don't address the varying conditions and problems that we confront.

Finally, Mr. Chairman, I like very much the notion of demonstration grants, because I think this gives an opportunity for local initiative and the chance for individual tribes to come forward with a creative approach to dealing with the problems that we confront. And then we would be able to look at those programs, see which ones have been successful, and, again, if we have had some geographic distribution, try different approaches in different parts of the country and hopefully apply the ones that work to those areas that have not had a chance to participate.

So, Mr. Chairman, I do, again, want to commend the Senator from Arizona for his work on this bill. I do think it contains many elements which are worthy of support, and I hope that I am able to support it as we are able to learn answers to some of these questions.

Senator McCain. I'd like to thank you, Senator Conrad, for your interest and concern on this legislation and on this terrible issue. I'd like to briefly respond—and perhaps in more detail later on.

I envision this would be new money—approximately $6 million per year. Frankly, I don't think that would have a significant impact on our budgetary deliberations and, therefore, since it would be new money, it would not have any effect on any other program.

I would look forward to the opportunity of working with my colleague from North Dakota in shaping an amendment to this legislation which would ensure an equitable distribution—perhaps by service area—of these funds so that we could get the kinds of experiences from different parts of the country that I think are necessary if we are going to shape an overall program.

I would look forward to working with you and your staff on perhaps getting an amendment to ensure that these funds and these grants would be distributed equitably throughout the country, because I am fully aware that there are certain problems in Alaska, there are certain problems in Arizona and North Dakota and Washington that, although a common thread is clear, there are unique situations—particularly when you bring in, as this legislation contemplates, the cultural treatment and some of the traditional treatments that Native Americans have found to be of a utility.

Senator Gorton.

STATEMENT OF HON. SLADE GORTON, U.S. SENATOR FROM WASHINGTON

Senator Gorton. Senator McCain, I want to join my colleagues in expressing my appreciation to you on two counts. The first count is the thought and effort and concern which has gone into drafting a bill designed to meet a very real need. Second, I appreciate your giving this formal opportunity both for members and for witnesses to comment on the proposal.

I must say that I have a problem or a challenge, which is the reverse or the mirror image of that indicated by the Senator from Alaska. Much of the Indian population in the State of Washington is urban rather than rural. One of your witnesses here today whose testimony I will inevitably miss because of a conflict is Doctor Dale Walker, a member of the board of directors of the Seattle Indian Health Board. That Board operates the Thunderbird Treatment Center, which is the largest Indian-operated alcoholism and drug treatment facility anywhere in the United States whose client population has included members of some 220 different tribes or Indian groups.

The bill, as his testimony will indicate, as it is presently drafted, does not provide for demonstration projects in urban areas. I rather suspect that that's something of an oversight. I want very much to join as a cosponsor in this effort. I simply want to take the opportunity to say that I would like to be able to work out something so that it is broadly inclusive enough as to include our people. But that's a minor criticism at this point of what seems to me to be a very important step that is, indeed, a very, very real problem.

Senator McCAIN. I thank my friend from Washington. Clearly there is a need for designation of certain amounts of these grants to be for urban areas, and I would look forward to working with him and his staff as we make sure that there is clearly an equitable distribution.

Again, I think the point that my friend makes is important because the urban Indian does have some different problems than Native Alaskans who are Navajos or others. So I think it would be very important that we take that into consideration and do that.

I thank you very much.

Our next witness will be a man I am always pleased to have before the committee, a former director of the Indian Health Service and a man of enormous credibility everywhere in America, Dr. Emory Johnson.

Dr. Johnson, welcome back.

STATEMENT OF DR. EMORY JOHNSON, REPRESENTING CHEYENNE RIVER SIOUX TRIBE, EAGLE BUTTE, SD

Dr. JOHNSON. Thank you, Senator McCain.

I am here today because Chairman Wayne Ducheneaux of the Cheyenne River Sioux Tribe is entertaining the Assistant Secretary for Indian Affairs, Ed Brown, on the Cheyenne River Reservation today. But Chairman Ducheneaux has some very, very strong feelings about this bill and this approach, and I would like to share with you some of his support—the support of the Cheyenne River Sioux Tribe.

You mentioned earlier the two approaches to be used toward looking at mental health. The one is simply developing a master plan and going out and trying to implement it versus an incremental approach where you go out and try to identify from the grass roots up things that can be done and things that will work. You came down on the side of the latter, and I think you're absolutely correct on that.

I believe that the problems of mental health in Indian communities are so diverse. We have already heard Senator Murkowski about the bush of Alaska, Senator Gorton on the urban areas in Seattle, and all of us can tell stories about differences of tribes throughout the country.

I don't believe that anyone knows precisely what the best approach is to deal with Indian mental health, and I think until we do some of these things and try some of these things we're not going to know. The potential is to generate a massive amount of effort and come back 5 or 10 years from now and say what worked. We won't know.

This approach, I think, is a very reasonable and important one.

I'd also like to emphasize something else, and that is that to provide incentive for local initiative I think is extremely important. I happen to believe that most of the answers to our problems are out there in those communities. The people know what their problems are, they know what their strengths and their weaknesses are. They need a little bit of help.

I am on the advisory board for the Robert Wood Johnson Foundation—a program that they have called "Improving the health of Native Americans." We had, in this last year's cycle, 192 applications from Indian tribes for innovative programs dealing with ways to improve their health, most of which, as I recall, were related one way or another to the issue of mental health—alcoholism, self esteem, supporting the cultural development, and so forth—so you get a stable community to displace the dysfunctional communities and families that we now see so frequently.

Unfortunately, the Robert Wood Johnson Foundation was only able to fund 13 of that 192 to the tune of about $2 million. We're going to have another round this coming year, but that's still a very small amount.

But I think it demonstrates the need out there and the perception on the part of the tribal governments that there are things that they could do, and they need some help.

The Johnson Foundation has been very much involved in just dealing with medical schools and very high tech kinds of organizations. This is really their first attempt to deal with what I would call grass roots development of programs, and we were all a little bit concerned what the board of trustees response would be to the kind of project proposals that came in. I'm very pleased to note to you that the board of trustees was extremely pleased with the quality and the perception of the need and their solutions for it such that they have agreed now to go on with a second year of the program.

I also wanted to add some other points. Clearly the major improvements in Indian health over the next decade or so are going to be based on changes in behavior. As I have said many times before this committee and others, the Indian Health Service and the tribal leaders have done all the easy things. We've done all the things that the general community understands how to do. We're now out again, as we have been from time to time in the past, sort of out ahead of the curve trying to figure out answers to things that nobody in the larger community understands how to deal with. This country hasn't understood how to deal with alcoholism or substance abuse in the general population, and yet here we are with the Indian population again attempting to find our own solutions to it.

The idea of having demonstration grants—and a special appropriation for demonstration grants I think is really critical right now—and I don't know whether Doctor Rhoades will be able to confirm this in his testimony, but I can tell you for a fact that the Indian Health Service is under great stress right now simply meeting the day-to-day needs of providing acute medical care and those basic preventive services that any competent health program has got to deal with.

We are talking about trying to invest in some potentially high risk programs and projects, and it is very difficult for Doctor Rhoades, I think, to take money out of basic services and invest it in something that may turn out not to be the greatest idea when you get down the road apiece.

You've probably seen the article in the Washington Post this morning that talks about the crisis in emergency rooms in emergency medical care in the United States. Well, the Indian Health Service has sort of been in that mode for as long as I can recall, and that's something like 35 years.

Senator McCAIN. And it's getting worse.

Dr. JOHNSON. And it's getting worse. And so, therefore, unless there is something that really says we in the Congress believe it is important that you invest in this kind of activity and say here's the money to do that, I think it is going to be very, very difficult for that to happen.

Now, as far as the Cheyenne River Sioux Tribe is concerned, they have taken very seriously as a tribal government this issue. They have passed a bitribal resolution to make their reservation a substance abuse free reservation by the year 2000. There are two small communities on the Cheyenne River that already have declared themselves alcohol and substance free communities, and they have signs at the edge of the community telling you that. And if you are going to be drinking or something in there, they will escort you out of that community.

The Cheyenne River Sioux Tribe took a look at law enforcement, and clearly the people that show up in that jail are there because of alcohol and substance abuse. Of the folks that are in jails, 90 to 95 percent are there for that reason and that reason, alone.

Senator McCAIN. And how many of those people need mental help?

Dr. JOHNSON. I don't know that anybody has really defined that. But certainly when you besot your brain with alcohol for a while you have yourself at least an organic mental disorder. Now, how many of those come in there with a constitutional mental disorder? Maybe Doctor Rhoades can answer that one. I couldn't.

But the point that Chairman Ducheneaux and the tribe have made is that we don't believe we're going to solve the problem by simply putting people into jail and drying them out and then sending them back out into the community. So what the propose is to convert their jail—they're supposed to be building a new one, and they won't build a standard jail. They're going to build a detention center which is basically designed to be an alcohol and substance abuse treatment center.

Now, if that model, in fact, will work and we can make a difference instead of this revolving door of folks in and out of the local jail—the drunk tank. Get sobered up and back out and next weekend we're back in again. If, in fact, this approach that the Cheyenne River Sioux Tribe wants to make—and this has been done with a lot of support from Doctor Rhoades and his staff, from the Bureau, and support from the National Academy of Public Administration that did a major jail survey for the Bureau of Indian Affairs—if this sort of thing works, think how that changes the dynamics of the kind of resources that are being devoted to the treatment of alcohol and substance abuse on the reservations. It is an incredibly important approach to change that mentality as to how we deal with substance abuse. And this came out of the tribal government, and this is their commitment, and they have dug their heels in and said we're not going to do a traditional jail.

Now, the bill that you have here is the kind of bill that I think encourages and supports that kind of local initiative on the part of the tribe, and I believe that's an absolutely essential next step that we're going to have to take.

I would like to commend you personally, and also from the standpoint of the Cheyenne River Sioux Tribe. We thank you for this bill.

[Prepared statement of Dr. Johnson appears in appendix.]

Senator McCAIN. Thank you, Dr. Johnson. Your written statement will also be made a part of the record.

Ms. Jenny Rodgers, who is the Acting Department Director of the Navajo Department of Health, Navajo Nation, in Window Rock, Arizona, will be next.

Welcome, Ms. Rodgers.

STATEMENT OF JENNY RODGERS, M.P.H., ACTING DEPARTMENT DIRECTOR, NAVAJO DEPARTMENT OF HEALTH, NAVAJO NATION, WINDOW ROCK, AZ

Ms. RODGERS. Thank you.

Honorable members of the Senate Select Committee on Indian Affairs. I am Jenny Rodgers, Acting Department Director for the Department of Health for the Navajo Nation. On behalf of the Navajo Nation I would like to thank you for the opportunity to talk with you this afternoon regarding an issue of vital importance to the Navajo Nation and the Native American communities; that is, the provision of mental health care.

Mental health and related issues on Indian reservations have received very little attention to date. We find that behind just about every problem on the reservation mental health problems are at the core. Problems such as alcoholism, sexual abuse, school dropout, teenage pregnancy, and substance abuse, which arise out of and cause mental health problems, are critical areas which need to be addressed by the Indian nations with assistance from the Federal Government.

In order to illustrate the needs for mental health programs, I would like to provide you with some background statistics on the Navajo Nation.

As you know, the Navajo Nation covers 25,000 square miles, an area about the size of West Virginia, spanning the States of Arizona, New Mexico, and Utah. The Navajo Tribe is the largest in the United States, with a population of approximately 181,280.

The median age of the Navajo Tribe is 19.3, compared to a median age of the general U.S. population of 30. The Navajo birth rate is approximately 2.7 percent, which is three times the national average. Our per capita income is about $2,400, compared to the general U.S. per capita income of $12,287. Of the Navajos living on the reservation, 49 percent have incomes below the poverty level, while 9 percent of the general U.S. population have incomes below the poverty level. While unemployment in the United States has been reported to be approximately 5 percent, the Navajo unemployment rate is approximately 32 percent.

The Navajo population experiences a shorter life expectancy than the national average. Alcoholism and problems associated with cultural confusion and diffusion may contribute to this. Navajo young people, in particular, show serious problems with substance abuse, depression, and suicidal behavior. Consequently, many drop out of school, have diminished self esteem, and often a demoralized, dim view of the future.

These serious problems create a greater need for mental health services. Due to limited resources, the large number of people to be served, and the enormous service area, the demand greatly exceeds the supply. The Indian Health Service has a staff of only 45 persons functioning as mental health teams to serve the entire Navajo Nation. There are only three child psychiatrists on staff to cover the entire reservation. The Navajo Nation is served by six hospitals, but there is only one inpatient mental health ward, located at Gallup Indian Medical Center, which has a total of 14 beds. This ward has a long waiting list, on which some wait for two to three months for admission.

A survey of area psychiatrists indicates that less than 20 percent of patients needing hospitalization are seen. In addition, there is a complete absence of community-based and controlled mental health programs such as group homes, halfway houses, women's shelters, and culturally relevant counseling using Native American healing.

The Navajo Nation has some community-based programs in non-mental health areas, experiences upon which the nation can and needs to build upon in the area of mental health programs.

In addition, there is an overwhelming need for mental health services for children. Many Navajo children are confronted with enormous problems including alcoholism, family violence, sexual abuse, teenage pregnancy, and school dropouts. These problems are currently not being adequately addressed.

As an example, the recent case of sexual abuse of Navajo children by a teacher at the Lower Greasewood Boarding School also illustrates the need for counseling not only of the children that are abused, but also of sexual offenders.

We have several suggestions for solutions to these problems.

First, a dire need exists for innovative mental health programs integrating traditional native healing with western medicine where patients can receive the best of the two methodologies working hand in hand.

Many traditional Native Americans have difficulty responding to western medical techniques, certainly where confidence, open communications, trust, and understanding are integral parts of the healing process. Therefore, not only should traditional and western methodologies be integrated but, in addition, non-Indian medical personnel should be trained and familiarized with aspects of Native American medicine, culture, and traditions so that they may better empathize with and treat their Indian patients.

The sporadic, nonformal approach now used by some hospitals combining traditional Native American and western approaches should be formally integrated into the mental health system.

The second important aspect to consider is that these new mental health initiatives need to be accomplished by Native Americans, themselves. The extended family and clan relationships and the strong traditional ties that bind Navajos together can be used to build a program which Navajos can relate to and truly benefit from. Positive, innovative mental health programs administered by Native Americans would greatly contribute to Indian self-determination.

I commend the committee and Senator McCain for being sensitive to these considerations and for recognizing the dire need that exists for exploring mental health service options. S. 1270 provides opportunities to create innovative, community-based programs which may combine modern clinical approaches with culturally relevant Indian methods of treatment. We welcome the opportunity to explore various mental health care delivery systems and to encourage the committee to ensure the funding of such programs upon the completion of effective demonstration projects.

The Navajo Nation would like to make some suggestions for modifications to S. 1270. First, we would like to suggest that the grants planned by this measure be made available to tribes and tribal consortia through the Indian Self-Determination and Education Assistance Act, as amended—section 103(E)(2)—if the tribe or tribal organization so chooses that approach. This is a grant program familiar to both the tribes and tribal organizations, as well as to IHS, which provides the mechanism for making the contemplated grants.

In addition, if final approval authority for grant expenditures rests with the IHS on mental health plans designed by tribes, the respective mental health service efforts may be hamstrung with unnecessary red tape—especially with innovative projects involving traditional healing, where IHS has limited experience. Therefore, the final authority for approval of design, implementation, and expenditure of funds should rest with the tribes and tribal health authorities.

Finally, the bill requires the IHS to provide technical assistance to Indian tribes. However, it is unclear what kind of technical assistance would be provided. Would it include training? Additional equipment? Our concern is that these resources provide direct benefits and not just become an additional IHS administrative cost.

In conclusion, the Navajo Nation strongly supports S. 1270. We applaud the committee for turning its attention to the issue of mental health. Such efforts complement those launched by the Bush Administration to combat the Nation's drug problem.

I thank you for permitting us the opportunity to supply you with our views and would be happy to answer any questions you may have or to submit additional information as necessary.

[Prepared statement of Ms. Rodgers appears in appendix.]

Senator McCAIN. Thank you very much.

Ms. Nell Rogers and Ms. Greta Holly. Ms. Rogers is the Director of the Office of Education and Health Planning. Ms. Holly is Executive Director of Vocational Rehabilitation Services, Mississippi Band of Choctaw Indians, Philadelphia, Mississippi. Welcome.

STATEMENT OF NELL ROGERS, DIRECTOR, OFFICE OF EDUCATION AND HEALTH PLANNING, MISSISSIPPI BAND OF CHOCTAW INDIANS, PHILADELPHIA, MS, ACCOMPANIED BY GRETA HOLLY, EXECUTIVE DIRECTOR, VOCATIONAL REHABILITATION SERVICES

Ms. ROGERS. Thank you.

I'm Nell Rogers, and I am a planner for the Mississippi Choctaw. I almost feel, Mr. Chairman, that I should concur with Doctor Johnson's comments about the overextension of Indian Health Service and the fact that tribes are just beginning to attempt to solve their real problems and conclude my comments with that, but I think Chief Martin would be very unhappy. So I will say that I agree with Doctor Johnson and will continue.

With me today is Greta Holly, who is Director of the Choctaw Rehabilitation Services. It is a very special and successful program for mentally and physically disabled Choctaw adults.

On behalf of Tribal Chief Phillip Martin, we are grateful to have the opportunity to speak in favor of S. 1270. It is a very positive and creative bill. It is one which addresses, in a sensible manner, a profound problem for the Mississippi Choctaws and one which I suspect is of equal seriousness for many other tribes.

In our remarks we will first outline the need for the legislation from the context of our own experience. We will describe what the tribe has done, using a combination of funds, to partially address the problem, and conclude with the importance of this bill to that effort.

The Mississippi Choctaws have worked with purpose to achieve community and economic development, applying diligent attention to developing the tribe's only resource, its people and their will to work. And in this regard, the tribe has been exceptionally successful, creating over 1,400 private sector jobs since 1979.

The unemployment rate at Choctaw has been reduced by half. And of particular importance, we think, only 5 percent of household income on the reservation now comes from public assistance.

While the tribe is understandably proud of its record, there is one segment of the population, the mentally disabled and the mentally ill, who were unable to benefit from these new economic and community initiatives. Their untreated conditions and their need for specialized training and other services made employment impossible. For these tribal members, it became apparent that simple training or treatment alone was not enough if they were to become functional and engaged in a productive life.

So 3 years ago, in recognition of this, the tribe set out to find the best means of treatment and rehabilitation. We conducted some research and interviewed people. Through our investigations we found that few of the disabled had only one problem or condition. Instead, many suffered damage from long-term alcohol abuse which created physical and mental disability. Others had physical disabilities or such extremely limited skills which contributed to mental illnesses. It was clear that efforts to approach their problem separately hadn't been successful.

So our goal was to put together a service plan that would treat, as much as possible, the multiple problems of each person. We found, not surprisingly, that there was no agency or program with either the funds or the inclination to support such a comprehensive, yet alternative approach. IHS funds, as we all know, are severely limited. State services are generally only available off the reservation, and none are flexible enough to address all of the parts of an individual's problem.

Our only solution was to try to put together funds from several sources and administer them in an umbrella fashion. Now, after 2 years, we have such a program which, as Greta will tell you with more specificity, is working so well in helping the mentally disabled overcome their limitations.

In concluding my remarks, I have to say that working at Choctaw has always been an exciting and challenging job, but the most satisfying personal and professional experience I have had has been to see the changes in the lives of people who are participating in this program. I wish that you could see the clients—that you could know their case history and see the remarkable changes that are occurring in their lives—particularly in those that have never been able to have a job before.

Quite frankly, the adult mentally ill and mentally retarded and mentally disabled population has always been a population that has been left out. They are a population for whom there have been no options once they left the school system.

S. 1270, I believe, is so important because it will give tribes the opportunity to develop their own destinies of treatment and rehabilitation, but without their having to resort to this patchwork method that we followed.

Greta is going to describe for you how what we call our "house of cards" program is funded, what the services are, and how the clients have benefitted. I think that this will give you a chance to understand not only the obstacles that tribes face in developing comprehensive programs for mentally ill, but it will also give you a chance to see what is possible when you can develop a comprehensive service program.

Greta.

STATEMENT OF GRETA HOLLY

Ms. HOLLY. Mr. Chairman, I am Greta Holly. I, too, am very pleased to be able to testify in support of S. 1270 since I believe that our success with a different kind of program stands as a strong indicator of the need for demonstration grants such as those proposed in the bill.

Rather than limiting itself to simply counseling as a means of dealing with the conditions of the clients, our program provides a full range of services: psychological counselling and therapy, psychometric assessment, vocational evaluation and counselling, case management, work adjustment training, job skills training and placement, and followup counselling and post-employment services.

Our staff and the program services are provided from a number of sources: the Rehabilitation Services Administration and the Indian Vocational Education Program in the U.S. Department of Education and the EARN—Employment Assistance Readiness Network—Demonstration program sponsored by the Bureau of Indian Affairs social services program.

In addition, our clients receive literacy and GED education from the Choctaw Adult Education program, health care from the Choctaw Health Center, psychological counselling and evaluation from Choctaw Mental Health, and some physical restorations from State rehabilitation services.

As a direct result of these services this year, 55 adults—most of whom had never been employed—have been placed and remain in competitive employment. We are very proud of this accomplishment.

Once the program began operation, we found that the extent of the need was far greater than anticipated. We are serving 88 clients now; however, we have a waiting list of 312, most of whom have already been evaluated and found eligible for services. Over 70 percent have mental disabilities which include retardation, alcohol and substance abuse damage, emotional disturbances, and learning disabilities. At least 50 percent of our clients have an alcohol or substance abuse problem as a secondary disability which can undermine the rehabilitation effort unless that, too, is addressed and controlled.

My experience with clients who have mental problems has been that the most important areas which must be addressed are those of helping the clients find a purpose in life, developing feelings of self-worth, and to develop independence and self-sufficiency. The most effective way that we have found to address these issues has been to take a holistic approach. An integral part of that is assisting clients with employment goals.

As part of that program, we provide job skills training in three areas: the first is industrial training, which provides training in industrial assembly jobs and general work skills transferrable to many locations; second is horticultural training, which provides training in general work skills and specific job skills needed for plants, vegetable, and fruit production and for the marketing of these products. This type of training is very successful for those clients who are unable to adapt to the more complex work setting of a manufacturing plant. The third training is field training, which provides training at a variety of businesses and industries, both on and off the reservation. This component provides greater options for employment development for the client.

We also provide sheltered employment when it is determined that chronically mentally ill clients cannot function in a competitive environment. These individuals are given the option of entering sheltered employment, usually in a satellite industrial site or at the greenhouse.

We knew, however, that simply providing this job skills training for the mentally disabled was not enough. This had already been attempted by our vocational training program. For those clients with mental problems, this approach falls short of providing them with the skills necessary to keep a job once attained and to cope with daily life situations.

Our clients receive many additional services: thorough assessment, followed by setting reasonable goals and objectives and developing an individualized plan for each person; job skills training for those for whom this is appropriate; work adjustment training which helps the client develop independent living skills and proper work habits and attitudes; and other services aimed at eliminating barriers to employment and productive community living. Extensive follow- up and related post-employment services are also provided to ensure continued vocational and personal success.

It is important to note here the importance of financial support for clients who are participating in our treatment and rehabilitation effort. For us, the BIA EARN demonstration program is meeting a longstanding need for incentive stipends for those who enter training. In the absence of these stipends, our clients who are in job training would only receive $115 per month in general assistance and TWEPT payments. This would not be enough to pay for their transportation, work clothing, and lunches.

The EARN project also provides a social worker who assists clients in solving transportation, home, and family problems in a manner which will foster independent problem solving by the client. A work adjustment counselor also aids them on work habits and interpersonal skills development.

Because we have found that it is important to speak to all aspects of the client's life in preparation for independent living, I am especially pleased to see that this bill proposes to address the previously misunderstood and sometimes ignored mental disabilities of American Indians which can surface and resurface, causing havoc both at home and at work.

The most effective way to combat this problem is to provide adequate evaluation to determine the nature of the client's mental health needs; implement a treatment plan which addresses each of the client's needs; to provide vocational rehabilitation services which will enable the client to be successful in a career; to implement a maintenance plan which will provide timely interventions when necessary, not when it is too late; and to involve the client in all planning with respect to his or her life.

It is imperative that each client have a complete and full understanding concerning the nature of his or her mental health needs so that there can be some individual responsibility assumed for seeing that the treatment and maintenance plans are followed. It is clear that S. 1270 would allow tribes and tribal organizations to begin to develop and test similar or other equally appropriate approaches to mental health care in their communities.

I would like to conclude with some recommendations and a word of caution. I believe that the activities allowed under the demonstration grants should include incentive stipends for training for any tribal members who have successfully completed an alcohol or substance abuse treatment plan and who want to participate in training—either in vocational training or in on-the-job training. It is vital to an individual's alcohol and substance abuse rehabilitation that training and employment opportunities be made available immediately upon completion of treatment so that discouragement and previously unproductive ways of behavior do not recur.

A growing problem for us is housing for the chronically mentally ill. A number of our clients—especially the most severely disabled—have no place to live or they live in undesirable settings. Most often they are single adults with no family or they have lost their families through adverse behavior.

There is great need for the legislation to support an examination of supervised living arrangements for the mentally ill, thereby avoiding institutionalization and assuring a community-based approach.

Right now, the options for caring for this population are marked by lack of funding, narrow focus, and a failure to develop comprehensive service plans. S. 1270 could answer these shortfalls. However, there must be provisions for the continuation of these demonstration programs if they are found to be effective.

One of the most damaging aspects program development for Indian tribes is that of inconsistent funding and policy. Indian populations—more than any other in this country—have repeatedly faced the disruptions of service programs due to policy changes. In the case of the mentally disabled, whose treatment and recovery require consistency, these changes are especially harmful. They do not have the flexibility and resources to move on to other options and their services must be continued on a daily basis.

We are particularly aware of the necessity for establishing and holding to a policy of consistency because in a few weeks our funding from the Rehabilitation Services Administration will end. This supports all of our professional staff for evaluation, counselling, placement, and sheltered employment. In other year, the BIA EARN demonstration project will end, unless both the Congress and BIA agree to its continuation.

State and Federal programs which serve the non-Indian mentally ill and mentally disabled are not generally subject to such funding uncertainties. I believe that S. 1270 can become the means through which Indian tribes can develop, test, and establish permanent programs for these vulnerable populations.

Thank you.

[The prepared statement of Ms. Rogers and Ms. Holly appear in appendix.]

Senator McCain. Thank you very much.

I'd like to recognize my friend from Mississippi, Senator Cochran, for any statement or questions he might have.

Senator Cochran. Mr. Chairman, thank you very much.

I'm glad to be able to attend this hearing to welcome our distinguished citizens from Mississippi, Nell Rogers and Greta Holly, who are here participating as members of this panel.

I also want to congratulate you, Mr. Chairman, on organizing the hearing on this very serious problem of mental illness and how it affects a number of Native American citizens.

The mental health demonstration project I think would do a great deal to provide us with additional information necessary to cope more effectively with the challenge of treating Native Americans. I think the benefit of the testimony we've already heard about the experience that we have had at the Mississippi Band of Choctaw Indians is very helpful.

I'm glad to be a cosponsor of your bill, and look forward to working with you in developing a strategy for getting this enacted.

Senator McCAIN. Thank you very much.

Senator COCHRAN. Thank you for recognizing me.

Senator McCAIN. Thank you. And I know that Ms. Rogers and Ms. Holly will convey our best regards to Chairman Phillip Martin, an outstanding leader of the Choctaw Tribe.

Senator Gorton, any questions?

Senator GORTON. No.

Senator McCAIN. I just have a couple of questions. Doctor Johnson, the issue, if I understand your statement correctly, is that alcohol and drug abuse and mental illness are inextricably intertwined; is that a fact in your view?

Dr. JOHNSON. I believe that a large proportion of them are intertwined. You do obviously have pure mental health patients without any overlay or compounding problems with alcohol or drug abuse.

Senator McCAIN. Does that make an argument that we should combine the mental health and alcohol and drug abuse offices and programs?

Dr. JOHNSON. I don't believe that necessarily follows, Senator McCain. That has been an argument that takes me back to the initial days of the alcohol program. I can argue on either side of that argument.

Certainly many of the tools that they use are the same. Many of the functions that they have to perform are the same. At the same time, there still remains a stigma in relationship to mental health.

We could spend a lot of time discussing this. Perhaps we can ask Dr. Rhoades, in your wisdom, to sort that one out. My preference, obviously, was the way it started out.

Senator McCAIN. On a priority basis, how important do you think that addressing this issue is in the overall scheme of the Indian Health Service?

Dr. JOHNSON. I think this has clearly got to be one of the most critical deficiencies of the Indian Health program. I think that's what makes it so extraordinarily difficult for the management of the program. On the one hand, you're constantly stressed with simply dealing with those acute emergencies that arrive at your door. You can't turn away from those that are suffering and are bleeding. You've got to deal with it. On the other hand, if all we do is treat those people, we'll never get ahead of the curve on preventing the kinds of things that ultimately would deal with that.

To give you the classic example, I guess, is if all we had done for infant mortality and the diarrhea in babies was simply to treat all those sick babies as they came in and put the IV tubes in their head, we'd still have the diarrhea wards and we'd still have the highest infant mortality in the country. But a certain amount of resource was invested in sanitation facilities construction, in health education and in public health nursing, in CHRs, and those kinds of things that create behavior changes and environmental changes. Now, what in the world—how do you determine how to balance that? I think that's the problem that we have right now.

I think the director is going to be increasingly stressed as the resources are compressed relative—not in gross numbers, but relative to the demand. We're talking about not meeting inflationary levels each year. We never talk about the increase in the work load that's coming from the increase in the population and increase in the aging—all things which create greater demands on the system. So you find yourself more and more constrained.

And so you almost find yourself forced to almost retreat to that. And I think that it has got to be clear that Congress has got to get some clear direction and put their money where their mouth is to say we've got to go out and start dealing with some of these prevention and health promotion and disease prevention activities because the director is being forced more and more to allocate limited resources by some sort of a formula, some sort of a needs- based objective kind of allocation which leaves less and less flexibility to take the chance and try some of these things. The Indian Health Service didn't make the kind of progress and the tribes didn't do it by simply doing the traditional things that white medical society does.

We did it by finding different ways of trying to meet these problems, and the climate right now is adverse to that kind of risk taking, I think. I think your investigating committee, I'm sorry to say, and I think the Inspector General and folks like that have a tendency to put a chilling effect on good, professional folks who are willing to work with the tribes and try to take a chance and try some things because we simply do not know the answers.

Senator McCAIN. Thank you.

Ms. Holly, how do you account for the extraordinary success of your program as opposed to other programs which have either failed or not shown the kind of significant results that yours has?

Ms. HOLLY. I think at Mississippi Choctaw our economic development has helped us quite a bit. As Nell mentioned, we have 1,400 private sector jobs. We are able to work with our employers on reservation and help to provide jobs.

The tribe has also supported the rehabilitation program to an extent that I don't know if other tribes are or not, but I do attribute it somewhat to that.

Again, we do have a real strong industrial base. The private sector also supports our program. And we do feel to meet the unmet needs of mental illness situations that you do have to approach the employment standpoint.

Senator McCAIN. Thank you.

Ms. Rodgers, what is being done to address the problems caused by Mr. Todd's sexual abuse of the school children?

Ms. RODGERS. Right now we have received about $100,000 from the States of Arizona and New Mexico for any kind of mental health program, which is very limited and, therefore, this is not being properly addressed because of the limited funds. We don't have staff. We don't have the facilities. And we don't have trained people out on the reservation to address the Indian people's problems.

Senator McCAIN. Would you send us a letter from the tribe indicating what the needs are in order to address the problem specifically of these young people that were abused by Mr. Todd?

Ms. RODGERS. Yes, we will.

Senator MCCAIN. Thank you. And thank you for being here.

Ms. Fernandez, thank you for coming and making the long trip. I read with interest your testimony and I agree with you that we should try to avoid the creation of another bureaucracy and we'll take that and your other recommendations on board for serious consideration. We always receive excellent input from the Inter Tribal Council, and we appreciate your presence here today.

Senator Gorton, do you have any questions?

Senator GORTON. No.

Senator MCCAIN. I thank the panel. Thank you all for being here.

The next witness is Doctor Everett Rhoades, who is accompanied by Doctors Scott Nelson, Craig Vanderwagon, and George McCoy of the Indian Health Service; and Doctor Denise Dougherty of the Office of Technology Assessment. Please come forward.

STATEMENT OF DR. EVERETT R. RHOADES, EXECUTIVE DIRECTOR, INDIAN HEALTH SERVICE, ROCKVILLE, MD, ACCOMPANIED BY DR. SCOTT NELSON, DR. CRAIG VANDERWAGON, AND DR. GEORGE McCOY

Dr. RHOADES. Thank you, Mr. Chairman.

As you pointed out, I am accompanied on my left by Doctor Craig Vanderwagon, the Director of our Division of Clinic Services in the Indian Health Service; and on my immediate right is Doctor Scott Nelson, the Chief of our Branch of Mental Health in the Indian Health Service; and on his immediate right is Doctor George McCoy, a staff physician in the Mental Health Branch.

Mr. Chairman, I searched in vain for your team this morning in the health run Potomac East as a contribution to the mental health——

Senator MCCAIN. My team was in the Capital Challenge. Is that what you're talking about?

Dr. RHOADES. Yes.

Senator MCCAIN. My staff member was a winner and got on the Today Show as a result of that and mentioned my name three times, so he's due for a raise. [Laughter.]

Dr. RHOADES. As a person who frequently has to say "but I am standing up," I couldn't survey that crowd very well.

Senator MCCAIN. We had a cardiac unit standing by knowing you were in the race.

Dr. RHOADES. Secretary Sullivan was also conspicuously present at the end of the three mile run.

I am very happy to be here to discuss this most important problem, Mr. Chairman. I appreciate your opening statements, and I also have looked very carefully at the comments in the Congressional Record of June the 23d upon your introduction of this bill.

I don't think I can add anything to the correct depiction of the status of the services available to Indian people for mental care. I appreciate your comment, as well, and I'd like to emphasize that the deficiencies that exist in no way are a reflection upon our handful of extraordinarily competent, professional, and dedicated individuals, particularly under the very excellent and visionary—if

I could use that term—leadership of Doctor Nelson since he has joined the Indian Health Service.

Assuming that my opening statement would be entered in the record, I'd just like to make a few comments about that along the lines of your interest in gaining additional information about the status of programs for Indian people.

This program, like all our programs, operates at the community level. It is the responsibility of a service unit, our basic organizational structure. Eighty percent of the program is operated directly by the Indian Health Service, and approximately 20 percent of the program is operated by tribes, themselves.

The most common model for a mental health program in the Indian Health Service is an outpatient service staffed by one or more mental health professionals, often, but not always, with the assistance of a local American Indian/Alaska Native mental health technician.

Inpatient services are available through several mechanisms in almost all service units. We operate two short-term psychiatric hospital inpatient units, a 14-bed unit available at Gallup Indian Medical Center, and a 9-bed unit in the Indian Health Service Hospital in Rapid City, South Dakota.

We utilize the services of Native healers extensively, and these activities, when combined with what I would call traditional western medicine, have proved to be very, very beneficial in caring for all kinds of illness, not just psychiatric illnesses.

In some areas, State and local community mental health programs also indeed provide services to Indian persons with emotional problems—diagnostic observation, transitional living programs, child residential mental health care—obtained from local and State programs where those resources are available.

In most of the Indian Health Service's, the primary funding for mental health services is provided in the line item categorical appropriation for mental health services in our budget which, for fiscal year 1989, was just over $13 million.

Based upon action on the 1990 budget thus far by the House and Senate, we expect the addition of somewhere between $5 million and $7 million, the latter figure representing a 58 percent increase in the level of resources available to this modest program.

As of April of this year, we had 236 staff funded out of these mental health funds. Of this, 198 are direct treatment staff. The remaining approximately 19 percent are administrative or clerical in one form or another.

The service unit direct care staff includes 45 mental health technicians, 52 social workers, 37 psychologists, 22 psychiatrists—and I could quickly divide that out and provide you the ratio of psychiatrists to the Indian population. But I think it is obvious from the number 22 that it is an exceedingly low ratio of psychiatrists to population. We have seven psychiatric nurse specialists and 32 members of various other disciplines. Of these, 190 are employed by the Indian Health Service and 46 are employed by tribal organizations.

Perhaps of some significance, I think, is the fact that of the 198, 109 are, in fact, Native Americans. On the other hand, only 17 have any training to provide services to children or adolescents.

These employees are distributed across 132 service units, or an average of about one and a half direct mental health treatment personnel in each service unit.

Some of the things that we are working to do at the present time to strengthen this program is the development of a comprehensive plan which is in draft. It is being circulated now. It will be rapidly coming to completion after comments from the field. It establishes services to children and adolescents as a priority for service and basically calls for an increase in the number of mental health staff in order to meet minimal levels of needs for mental health services according to a nationally accepted ratio of one mental health care provider for every 2,000 population.

We provide mental health consultation to tribes, other Indian Health Service facilities, and field personnel regarding strategies—particularly directed at suicide, which has been mentioned prominently this afternoon, and other forms of violent behavior, and for the development of child and adolescent mental health programs. This is a result of the establishment of a special initiatives team just 2½ years ago.

We have a quality assurance program which seeks to continually upgrade the quality of our existing program. And we have made considerable progress in the implementation of a collaborative agreement between the alcohol and substance abuse program and the mental health program, as one of your later questions addressed, as well. And we are increasing our cooperative activities with other agencies.

Mr. Chairman, at the present time I am working closely with members of the Department of Health and Human Services to strengthen our approach to the mental health problems encountered, as so well described this afternoon by yourself and the outside witnesses. We will undertake a comprehensive effort targeting all segments of the population emphasizing prevention as well as treatment efforts and emphasizing close cooperation between the Federal Government and the tribes.

With regard to the provisions of your bill, Senate bill 1270, creating ten mental health demonstration projects and programs and to establish a technical assistance office, I reluctantly sound negative about that, and I don't want my reluctance to be taken as any sort of negative feelings about the approach and the importance of approaching this problem.

However, it is my feeling that we do know a great deal about what is needed, and we certainly know a great deal about what we do not have at the present time. We just simply do not have the infrastructure distributed across Indian Country, so that it is my belief that demonstration projects are almost certain to describe or discover what we, in fact, know at the present time. If they don't do that, if they, indeed, are directed at some unique approaches, which is ordinarily the approach taken by a demonstration project, then I think a case could be made that they would be distributed among tribes, some of which may already have a sound program—and very likely that would be the case—continuing the unacceptable deficiency that is distributed across the United States.

So I would have to recommend that a more appropriate approach would be to build the infrastructure that we do know is needed, at least at this time, and the status of the development of our mental health program. I believe a more broad approach would more appropriately meet the needs of Indian people and have the greatest chance, in my opinion, of continuing our efforts to raise the status of health of all Indian people to the highest possible level.

I certainly hope that we could work with the committee—and I would be eager to do so—towards the achievement of goals which I think I certainly acknowledge are common; that is, a comprehensive, well-organized, and well-managed mental health delivery system that is carefully structured to meet the local needs of the people that we serve.

Mr. Chairman, I and my colleagues would be happy to attempt to answer any questions that you or other members might have.

[Prepared statement of Dr. Rhoades appears in appendix.]

Senator McCain. Thank you.

Dr. Dougherty, welcome back.

STATEMENT OF DENISE DOUGHERTY, OFFICE OF TECHNOLOGY ASSESSMENT

Ms. Dougherty. Thank you.

As you know, OTA has provided information to the committee previously on both the general health and the mental health of Indians, and on the strengths and weaknesses of the current health services for Indians.

In addition, the chairman of the Committee on Indian Affairs was one of the primary requesters on an assessment on adolescent health that OTA is currently working on. Along with that, he asked us to prepare a special report on services addressing the mental and emotional health needs of Indian adolescents.

This special report is in the final stages of preparation, but has not been released yet by OTA. However, today OTA can provide some general observations about mental health services for Indian adolescents based on that report.

Let me turn, first, to the need for mental health services for Indians and Indian adolescents. OTA's detailed examination of Indian health status information that was published in 1986 revealed substantial discrepancies between the health status of Indians living in Indian Health Service areas and the United States population taken as a whole. You'll remember from previous testimony that in the 3-year period centered in 1981, 37 percent of Indian deaths occurred in Indians younger than age 45, compared with only 12 percent of U.S. all races deaths occurring in that age group.

The reasons for these deaths are primarily social or external causes of deaths, including accidents, suicide, homicide,and alcohol abuse. These data suggest that Indians could benefit from mental health care.

More recent data we have been synthesizing on the mental health needs of Indian adolescents suggests that this group, in particular, needs mental health services. Compared to students in Minnesota, for example, Indian students who were surveyed are twice as likely to report being sad, discouraged, and hopeless, to feel that life is uninteresting, and to feel emotionally insecure. One out of five Indian adolescents report being depressed.

Given their fragile and stressed emotional health, it is not surprising that one out of five Indian females and one out of ten Indian males report having ever attempted suicide—most within 1 year of the survey date.

A review of recent mortality data suggests that the mortality rate from suicide is rising among 10- to 14-year-old Indians in IHS service areas, and in 1986 it was almost five times that of the U.S. all races population. The suicide death rate for 15- to 19-year-old Indians was almost three times that of the U.S. all races population.

Forty percent of Indian students surveyed by the University of Minnesota live in single parent households, compared to 17 percent of Minnesota students living in such households. Twelve percent of Indian students reported that one or both of their parents were dead. That compared to only 4 percent of Minnesota students reporting that. And 18 percent of Indian females reported being physically abused; 14 percent reported being sexually abused.

OTA's review of the literature on mental health needs of adolescents that will be forthcoming in our report suggests that these problems are longstanding in Indian communities, and were true to some degree among Indian adolescents of 20, even 50, years ago.

You have heard about the mental health services for Indians, and that for all ages of Indians they are extremely limited. It is striking that either 12 or 17—I'm not sure if I did my addition right—of the Indian Health Service direct care providers have been trained to work with children or adolescents, while 43 percent of the service population are children or adolescents. That's a striking discrepancy.

So it is a basic problem of resources. I agree with Dr. Rhoades on that. There is a basic problem with resources for providing mental health services to Indians of all ages. But our review found some additional issues that need to be addressed if mental health care is to be improved, and these include the need for information about the nature and extent of mental health problems among Indian adolescents; the need to make services consonant with the cultural, spiritual, and religious values of Indians; the need for community participation in the design and delivery of mental health services, including the participation of adolescents; the need for coordination with other IHS programs and with other local, State, and Federal agencies; and the need for information about the effectiveness of mental health services for Indian adolescents.

Although a great deal is known about how to treat the mental health problems of children and adolescents in general, a great deal more needs to be learned about treating Indian adolescents. We were unable to find in our review any scientifically rigorous research on the best way to approach Indian adolescents with mental health problems, and that made the task of preparing a report on options for Congressional consideration quite difficult, because we like to rely on scientifically credible information.

This isn't to say that current approaches to Indian mental health services are wrong, because OTA found a number of promising approaches to improving the mental health of adolescents, and these seemed deserving of more thorough evaluation. For example, the Laguna-Acoma Teen Center in rural New Mexico incorporates a number of features that experience suggests would help to improve the mental health of adolescents. The special initiative team that IHS has also seems deserving of thorough evaluation, as does the match up of the quality assurance program with information on the outcomes of mental health treatment.

Traditional approaches such as sweat lodges to helping Indian adolescents continue to be used and could be evaluated, as well.

In commenting specifically on your bill, S. 1270, we believe that setting aside funds for evaluations of innovative services could be extremely important to improving the health and wellbeing of young Indians now and in the future because it would provide an objective research base on which to build services. But it may be important to ensure funds for this demonstration program are distributed equitably to promising projects for a variety of Indians of all ages and with adequate assurances that rigorous evaluations will be done.

[Prepared statement of Ms. Dougherty appears in appendix.]

Senator McCAIN. Thank you very much, Dr. Dougherty. You always provide us with very important help and information, and we are very grateful for it.

In fact, Doctor Rhoades, I wonder if you disagree with Ms. Dougherty's statement here. She says "Setting aside funds for evaluations of innovative services could be extremely important to improving the health and wellbeing of young Indians now and in the future by providing an objective research base on which to build services." Do you agree with that statement?

Dr. RHOADES. There is no way to disagree with that. That obviously is an important statement.

I might just add, however, that I am a little—she goes on to say, then, in the next sentence, the thing that is perhaps as equally difficult for the director of Indian Health Service and which I think is probably paradoxical; that is: ensure that the funds are distributed equitably. I don't know exactly what that means. I think I know what that means, but I don't think that's compatible.

Senator McCAIN. I think she can respond. But I think what it means to me is the concerns raised by the previous witnesses that there not be a concentration of these funds in certain areas or certain ways.

Is that what you meant by that?

Ms. DOUGHERTY. I know there is concern that people who can write the best proposals may be the ones who get all the money.

Senator McCAIN. Exactly. And, as was pointed out by previous witnesses, there are urban Indians such as Senator Gorton's, and Native Alaskans, and rural and urban Indian tribes in Arizona, for example, that clearly have very different needs. I think that's what she meant by that, Doctor Rhoades.

But if you agree with her statement, I'm not sure how that jives with your concluding paragraph that says, "I question the usefulness of demonstrations at this stage of our mental health program, and I believe our future approach will be more broad." If you agree with Ms. Dougherty's statement, then how can—I'm not sure how that coincides with yours.

Dr. RHOADES. It is a matter of emphasis priority, Mr. McCain. I think that the likelihood that these funds would go to programs—

some of which were testified to today because they are going to write better proposals and the need is just as great—is going to cause an outcry from those communities that may need a psychiatrist right now. So it is a matter of timing and it is a matter of emphasis, I believe.

I think we should build a mental health program. I think we know more about what needs to be done and what has helped Indian people. I don't think there is necessarily a reason to believe that there is some mystery about treating Indian adolescents with mental health problems compared with other adolescents, and I think there has been some demonstration already.

I just simply—and I don't want to talk additional information. We need that. I would prefer us to build a good program for each community and then explore some innovations.

Senator McCAIN. What kind of program would you contemplate?

Dr. RHOADES. The first thing I would do would be to have a well-qualified mental health worker in every service unit—in each of those 132 service units. We propose to have a psychiatrist or equivalent skilled in child abuse in at least each area. It is that relative preponderance of need that I believe probably addresses the question of equity as well as anything.

Senator McCAIN. That would be your program? Having qualified workers and qualified psychiatrists in each area?

Dr. RHOADES. I'm sorry?

Senator McCAIN. That would be your program?

Dr. RHOADES. That would be an element. I wouldn't pretend that that's the entire program. We need to establish day care centers for those who are chronically mentally ill who either have to go onto a waiting list in an inpatient service somewhere and perhaps not even be able to be paid for by our contract health care. We need to greatly increase our training.

One of the characteristics that is always going to be true of the Indian Health Service, in my opinion, is that we probably should never have an unacceptably high ratio of specialists; that is, our generalist physicians will have to provide most of the care. And just as we have to train those generalists when they come to us from medical schools in obstetrics—they are uncomfortable handling complicated obstetrical cases—we need to be training them in the recognition of these sorts of things right now.

I could ask Doctor Nelson, perhaps, to outline more completely some elements of what he proposes.

Senator McCAIN. You need that right now? Is that right?

Dr. RHOADES. Yes.

Senator McCAIN. You need that right now. Are you willing to ask for the funds that would be necessary to provide a qualified worker/psychiatrist in each area, expand day care centers, and increase training? And do you have any idea how much that would be?

Dr. RHOADES. I could provide that very quickly. We believe that the additional funds provided in 1990—I realize I'm anticipating an appropriation here—will take us a long ways in correcting that very thing. Perhaps I might ask Dr. Nelson to address that more specifically.

Senator McCAIN. Which is how much?

Dr. Rhoades. About $5 million, I think, would put a mental health worker in each service unit.

Let me ask Dr. Nelson to make sure I don't make an error.

Dr. Nelson. Well, I think that what Dr. Rhoades says is our understanding of what the Congress is considering, Senator McCain; that is, an expansion of that program.

I might amplify on what Dr. Rhoades says in the sense that I think that we know some of the principles that tribes have found to be effective in field in mental health programs. As he says, in general the resources are not adequate to fund enough of those. I guess it would be my sense that, to echo what some of the other witnesses have said, each tribe is going to have its own particular way of expressing its needs, of defining its programs, etc. And, therefore, there is going to be a difference based on each individual tribe's situation as to how a program can be best constructed.

Senator McCain. So $5 million is the anticipated increase in appropriations, and you think that will take care of the problem?

Dr. Nelson. No; I don't mean to say that. I think that what Dr. Rhoades said——

Senator McCain. My question is: What will take care of the problem? That was my initial question to Dr. Rhoades. What will take care of what the Office of Technology Assessment and every witness we have had before this committee says is an incredibly severe problem in statistics as stated by the Office of Technology Assessment stating that 43 percent of all—that's not what I was looking for——

Ms. Dougherty. Five times the rate of suicide among 10- to 14-year-olds?

Senator McCain. Yes; five times the rate of suicides.

Ms. Dougherty. And three times among the 15- to 19-year-olds?

Senator McCain. Three times. The $5 million is going to take care of the problem? If not, what is going to take care of the problem? It is my job and yours to come up with a plan that will take care of the problem. You have rejected out of hand our proposal because you say "I question the usefulness of demonstrations of our mental health program at this stage, and I believe our future approach will be more broad." I think it is appropriate to ask what your future approach will be and what is going to be required to take care of a situation where the mortality rate from suicide is rising amongst 10- to 14-year-old Indians in IHS service areas. In 1985 it was 4.6 times that of the United States all races population. The suicide death rate for 15- to 19-year-old Indians was 2.6 times that of U.S. all races population that age in 1986.

The answer I've gotten from both of you so far is that $5 million, which is next year's appropriation increase, which will provide a qualified worker in each service area and a psychiatrist in each area, increased training, and provide day care centers, will solve the problem. What will solve the problem, Dr. Nelson?

Dr. Nelson. I think Dr. Rhoades has said that we are in the process of developing that specific approach, and I think the approach is suggested by our draft mental health plan, which has had input from numerous people in the field. I don't think we are prepared at this stage today to outline that plan because it is under discussion.

Senator McCAIN. You are aware of the problems. This is not a startling revelation to you.

Dr. NELSON. Right.

Senator McCAIN. The Office of Technology Assessment has provided you with concerning suicide rates, alcoholism——

Dr. NELSON. That's correct.

Senator McCAIN. If you have not visited Gallup, New Mexico, you have probably seen on television the scenes of hundreds of Indians lying in a drunk tank on Saturday night. I'm sure you have the information.

Dr. Nelson.

Senator McCAIN. Why is it that we have no ideas or proposals right now?

Dr. NELSON. I think we do have some ideas, Senator, and I think they are outlined in part and suggested in part by our draft national mental health plan, which is being circulated. In addition, as Dr. Rhoades just said, our more specific approach that is based on that plan and other issues is under preparation and discussion within the department.

Senator McCAIN. When do you think, Dr. Rhoades, that you will be able to come before this committee with a comprehensive plan in order to address a problem that has not just come upon us that has been longstanding, and one which, according to the testimony of all witnesses, continues to increase in severity for a variety of reasons, including the fact that our IHS budget has not been able to even keep up with ordinary inflation, much less the increase in health care costs, which we know are dramatically more than the average inflation rate? When do you think that you would be able to come before this committee to submit your plan to address these issues besides counting on a $5 million increase in appropriations next year, which, according to what I can tell, barely covers the inflation, much less the increase in health care costs?

Dr. RHOADES. Mr. Chairman, let me reemphasize that in no way in responding to the question about whether or not $5 million would solve the problem—I obviously was responding to your question about what we are doing right now and what I think is the first thing that ought to be done. I still think the first thing to be done is to make basic services available to all the service units.

We have asked for comments to be completed to us by the 15th of this month, which I guess is tomorrow. This probably will dribble in over the next few days. I believe that we can have those assembled into a final plan which obviously would have to be cleared through the department within several weeks, at the most.

Senator McCAIN. While you develop your comprehensive plan, would it be of any use to allow the tribes an opportunity to demonstrate their plans and capabilities?

Dr. RHOADES. Yes, indeed. And I think we support that as vigorously as anybody else would.

Senator McCAIN. Thank you very much. I have no further questions. Thank you very much.

Our next witnesses will be: Dr. Eidell Wasserman, Ph.D., of the Hopi Sexual Abuse Project, Hopi Tribe; Hon. Lloyd Irvine, Council Member, and Mr. Joe Dupuis, Tribal Executive Secretary, Confederated Salish & Kootenai Tribe, Pablo, Montana; Ms. Vi Johnson, Director of the Department of Health Services, Gila River Indian Tribe, Sacaton, Arizona; Dr. Dale Walker, Seattle Indian Health Board, Seattle, Washington; and Ms. Susan Soule, who is the Coordinator of Rural and Native Services for the Division of Mental Health, Department of Health & Social Services, on behalf of the Honorable Myra Munson, Commissioner, Department of Health & Social Services of Juneau, Alaska.

Thank all of you for coming today. I appreciate your being here. I'd like to ask, to start with, for correction of my mispronunciation of Mr. Joe Dupuis.

Mr. DUPUIS. Joe Dupuis.

Senator MCCAIN. Dupuis. Thank you, Mr. Dupuis.

Governor White, welcome. It is good to see you again. Thank you for attending today. It is always a pleasure to see you here on this very important issue that I know is very important to the people of your tribe.

Dr. Wasserman.

STATEMENT OF EIDELL WASSERMAN, HOPI SEXUAL ABUSE PROJECT, HOPI TRIBE, KYKOTSMOVI, AZ

Ms. WASSERMAN. Thank you.

My name is Eidell Wasserman, and I am a clinical psychologist and project director of the Hopi Special Child Sexual Abuse Project.

I want to thank Senator McCain and his staff for inviting me to be here this afternoon. However, due to the short notice I haven't yet prepared a written statement, which I will submit.

Senator MCCAIN. It will be included for the record when you submit it.

Ms. WASSERMAN. Thank you.

What I would like to do very briefly is respond to the testimony which you just heard and to utilize the situation at Hopi as a case example of the effects of abuse, the resources that were needed, the resources that were available and are currently available through the Indian Health Service, and a concluding statement about the work that we have been doing.

Just in terms of a response to the previous testimony, Dr. Rhoades indicated that the Indian Health Service is well aware of the need and that there are programs out there. I would hope that he considers our program to be one of those. But I would ask how IHS has supported those programs, both in terms of funding and in terms of logistics.

In terms of treatment for child sexual abuse and the special project, we have not received any funding from Indian Health Service, nor have we received any type of logistical support in terms of housing, office space, etc. On occasion they do put up our clinical consultants in a trailer every other week for one night.

We have received logistical support from the branch of Infant and Maternal Care at the Phoenix Area Office, and I'd like to acknowledge their support of our program.

As far as the issue of generalists and providing training, certainly specialists are hard to come by, and we have had the problem, ourself. But I haven't seen the kind of training that Dr. Rhoades was talking about. There is a chronic turnover, I think, not just in Indian Health Service but in other programs. I don't know what training is provided on an ongoing basis to physicians, for example, in doing medical and interview evaluation.

I think, just like in any other area, some service units have skilled personnel, some do not. And this is a very critical issue, as you are very aware, and all of us in Arizona as well as other places are, when it is not an immediate evaluation of the child victim after a long term of the incident. Medical and interviewing evaluation is rarely available, and, in terms of financial need, that's not necessarily considered a priority. It is not an acute condition which can be paid for from Indian Health Service funds.

In terms of inpatient services, which is of a great concern to us, those services are simply not available. I don't need to repeat what other people have said, except to potentially emphasize the fact that oftentimes child sexual abuse victims who become child and adolescent perpetrators need some type of inpatient treatment, and that treatment currently is not available. We always have a fight with Indian Health Service to decide whether or not they're going to be able to pay for that kind of treatment.

We currently have, for example, an 11-year-old boy who was placed in foster care, who sexually abused a 4-year-old who was the foster parents' son, and the parents have been extremely uncooperative in getting him an outpatient evaluation through our program. The tribal judge has cited them for contempt and issued a warrant for their arrest, but that doesn't help the child to get treatment.

Our tribal social services program is out of money because it is the end of the fiscal year, and we're looking at $450 a day to put that child into inpatient hospitalization, which he clearly needs. He's currently living in a home with a 6-year-old child, and he's currently attending school with a number of other children. It is clearly not the kind of situation that we would like to have existing.

Certainly traditional and western methods to complement each other, but they are certainly not sufficient to resolve all mental health issues—and particularly in the issue that I deal with, both in terms of victimization by child sexual abuse and child perpetrators. There needs to be ongoing treatment available.

You also are aware that in the State of Arizona, as has been pointed out, there are no State mental health services available in terms of inpatient care. And for our population there aren't local community mental health centers available any closer than border towns, which are often inaccessible to the population at Hopi.

I think the fact that there are only 17 direct service workers who are trained to deliver services to children and adolescents does need to be highlighted, and I'd kind of like to know what the definition of "trained" is—whether those are people that really have degrees in child psychiatry and child psychology—and how many of those have specializations in child sexual abuse, which is a whole other ball of wax entirely.

The special initiatives team, through IHS, is a great idea, but I'm not entirely sure, through my understanding of it, how three people can provide mental health consultation for prevention to all of the Indian tribes, as well as be responsible for providing crisis and emergency work to all of the Indian tribes in the country.

Quality assurance is definitely something that's needed. It's a great idea. And I wonder how IHS has accounted for funds that have previously been appropriated for their direct service work in the past.

Again, plans for prevention are a great idea, but I'm not sure exactly what it is that Indian Health Service actually does in the field of prevention. And, again, in terms of child sexual abuse, as far as I know we are the only people on Hopi that are providing that service. And we've managed to provide prevention workshops to over 1,000 people, including 500 children, through community mobilization and volunteer efforts, as well as through our paid staff.

I would be remiss to not say that we do have $5,000 from the Indian Health Service Health Emphasis Campaign to support the prevention activities that we were already involved in.

So those would be my questions in regard to the previous testimony.

Briefly, the situation at Hopi I know is very well known to you and I don't want to go into that. But in terms of the effect of abuse on kids, let me just say that we see those effects and we continue to see those effects in every aspect of a child's life: academically, in terms of retention, dropping out of school, in-class behavior problems; socially, in difficulty forming age-appropriate relationships, social isolation and ridicule; psychologically in the feelings of shame, guilt, gender identity confusion, decreased self esteem, inability to trust authority figures, and lack of respect for adults; behavior problems in terms of infractions of the law, substance abuse, physical aggression, and becoming perpetrators themselves. And this is an ongoing problem.

The day that I left Hopi we had a crisis situation of a Boone victim who is now in early adulthood years. He is a teenage father. He has had several infractions with the law. He has never, to my knowledge, received treatment or been willing to receive treatment, although it has been offered to him, for his victimization. He recently became suicidal, citing the shame of his victimization and making statements that he couldn't live with that and that he was going to take his brother with him when he killed himself. This is a situation which arose 3 days ago—how many months and years after he was victimized by John Boone?

The community response is similar in terms of a lot of the shame and denial, the isolation of victims, and some people just plainly acknowledging that they basically have lost a generation of boys in one area, and, of course, the perpetration of abuse.

But the positive aspects of community response also need to be highlighted: The community mobilization, the increase in community awareness and interest in abuse issues, the prevention efforts that have been undertaken by community volunteers, and the utilization of self-help groups like Parents Anonymous, who has a contract with Vista, and we currently have two Hopi parents employed with our program through Vista working to promote child abuse prevention in their community—the positive efforts of the community, I would certainly like to underscore and appreciate.

In terms of resources, I just jotted down the first dozen or so that came to my mind: the lack of resources in terms of hospitalizing victims that need inpatient hospitalization; the lack of services for perpetrators that has been mentioned, but really needs to be highlighted.

Perpetrators, even when they're convicted in tribal court, are often released because of the short sentences that they can be handed in that situation. We have one perpetrator now who was convicted, served his time, and now he is out on the streets again and is awaiting Federal prosecution. I don't know how long that's going to take, but that is often a very lengthy process, during which time the perpetrator is out and about in the community, and during which time we very definitely do not have services to provide in terms of any kind of treatment.

Other things that came to my mind included the lack of prevention that I cited; the lack of ability to provide meaningful crisis intervention and emergency response not just at that very instant, but an ongoing kind of crisis intervention and emergency response, either in the community facing a multiple-victim molest or some other kind of problem; the training that needs to be ongoing and also needs to be delivered on site so that it is available to service providers as well as community members; specialists that are needed; the development of community resources and making resources available to community members, who can then go on to aid in the prevention and education.

There is a lack of foster homes that are available specifically to deal with abuse victims. Oftentimes abuse victims act out in ways that make them very difficult to control and they need specialized help. Currently, tribal social services have a dearth of foster homes, anyway, let alone those that are set up to handle such severe behavior problems.

Also, there is the need for development money which recognizes the lack of resources and the need for start-up times for programs. In preparation for this, when I asked some of my staff, who are parents in the community, what IHS provides, they kind of laughed and didn't really have anything to say in terms of services that they had been able to access in this specific issue of child sexual abuse.

The resources clearly are inadequate. I don't think that anybody argues with that fact. They are inadequate to deal with ordinary levels of abuse, if there is such a thing, let alone the multiple kinds of victims of sexual abuse that we've seen at several reservation areas.

The focus, of course, in Indian Health Service has been on medical treatment, and even within the social work area it is focused on medical social work dealing with acute psychiatric disorders and not long-term mental health problems.

Mental health programs, of course, are understaffed and lack specialized staff. And there is always a fight in our service unit between inpatient money that may be used for mental health needs versus medical needs. It is all in one pot. Whenever we have an inpatient money, we need to fight with the medical establishment.

I wonder, also, in response to the previous testimony, what kind of feedback is being solicited, whether that is feedback that is being solicited in the draft proposal in terms of IHS health workers. Personally, I haven't seen a copy of that. I'm not necessarily offended, but I might have some input, working in the mental health area on a reservation. That could be useful. And I wonder whether other service providers, like myself, might be able to use our experience in the comment stage of that kind of a proposal.

Very briefly—again, aware of the time—basically what the special project does is to provide prevention, community outreach, education, and treatment. And I think that we do it very well.

The need for ongoing funding for demonstration programs cannot be over emphasized, and I think that you can look to our program as an example. That was, in fact, funded as a demonstration project back in 1987 with no provision made for ongoing funding if the program were successful. Thanks to your support, Senator McCain, and your staff, we have now received ongoing funding—or at least funding for this year and hopefully, with the passage of the appropriations for the Department of the Interior Budget, we will receive funding for next year.

But I think that our program and the problems that we have had getting follow-up funding really speak to the need to address the issue that others have brought up. And in two other considerations of the proposed legislation—that the demonstration program address the issue or at least consider the issue of developing residential programs on reservations, that that would be an allowable type of program; and possibly the option for inpatient treatment since no other funds seem to be available for those kinds of services when they're needed. The third recommendation or consideration that our health department had was to streamline the reporting procedures.

The questions that were asked were: how is this information that comes from the programs going to be used? What are the implications for the future in terms of the numbers of statistics that will be provided by the programs that are funded under this legislation?

In conclusion, I'd like to express my deep appreciation to the committee for its ongoing concern for Indian children, and, personally, my support. I'd like to thank you very much for your support of our program.

Senator McCain. Thank you, Doctor Wasserman. And I express the view of many Arizonans when I thank you for your efforts on behalf of these young children who have been the victim of such terrible crimes perpetrated on them. Thank you.

Hon. Lloyd Irvine and Mr. Joe Dupuis, welcome.

STATEMENT OF HON. LLOYD IRVINE, COUNCIL MEMBER, CONFEDERATED SALISH & KOOTENIA TRIBE, PABLO, MT, ACCOMPANIED BY JOE DUPUIS, TRIBAL EXECUTIVE SECRETARY

Mr. Irvine. Mr. Chairman, Mr. Vice Chairman, and distinguished members of the Indian Affairs Committee, my name is Lloyd Irvine, and I am an elected official of the Confederated Salish & Kootenai Tribe.

Our reservation is located in Western Montana, approximately one and a quarter million acres of land. We have a tribal population of approximately 6,500 people.

I am accompanied today by Mr. Joe Dupuis, our tribal secretary.

We are pleased to present testimony on Senate bill 1270, legislation to establish an Indian Mental Health Demonstration Grant program to be administered by the Indian Health Service.

We want to begin by expressing our sincere thanks to Senator McCain for realizing the need for increased attention to the health care needs of the Indian people and for proposing this significant first step that could lead to a restructuring of the existing program. We concur in the Vice Chairman's opinion that the existing IHS mental health is severely underfunded and that the extent to which it is not a priority at IHS is demonstrated by the fact that only three percent of the IHS budget is dedicated to mental health, although this severe underfunding is certainly not limited to mental health.

We also agree and are elected with the recognition that Indian communities should be allowed to design a mental health program including the combining of existing clinical approaches with traditional cultural approaches. If we didn't know better, we would have thought that Senator McCain was familiar with the mental health program on the Flathead Reservation when this bill was conceptualized because it follows our program's philosophy. It is for this reason that we asked to be allowed to testify to tell you about the exciting and positive things we are doing on Flathead in this area.

On the Flathead Reservation we have contracted the mental health services program and are the only tribe in the IHS Billings Area to do so. Our approach is somewhat unique and has led to our mental health/social programs receiving a group citation award from the director of Indian Health Service on November 7, 1988.

We won this award because we use a multi-disciplinary team approach. When we staff a case we get a referral and a mental health worker first does an intake. We take that information to a staffing team that consists of representatives from our juvenile probation program, tribal courts, social workers, our alcohol program, our narcotics addiction service, the service unit director from the Indian Health Services, a registered nurse, and a psychiatrist.

Therefore, when we staff a case, because of the information that each one of those team members brings to the staffing, we end up with good information about that patient, the patient's background information, and frequently even a good history about the patient's family.

What may be most unique about our mental health program is its three components, including its strong emphasis on traditional cultural care. These components are: one, a strong clinical component which includes more standard forms of non-Indian mental health care including psychiatrists, clinical psychologists, and paraprofessionals using existing clinical approaches for the provision of psychological care.

Two, a very strong program involving the cultural aspects of our tribe utilizing our tribal elders, including meetings in our longhouses on a weekly basis. Our cultural specialist gives specific cultural recommendations or refers that person out to be seen by other cultural specialists of our tribe.

Three, we have a very strong community emphasis and involvement working with other community programs, including groups such as the Adult Survivors, the Community Health Representative—CHR—program, the Alcoholism program, and others.

Under a more standard mental health program, there would only be a social worker and a psychologist or a psychiatrist, and it is not really multidisciplinary. Our tribe allows us to access all tribal programs into our staffing, and that is what makes it unique. We have great cooperation with different programs.

We like Senate bill 1270 in that it seems to acknowledge the benefits that can come from traditional beliefs and traditional practices and encourages utilizing those practices into standard mental health practices. We believe very strongly in this approach. We have worked toward trying to perfect this practice for many years and feel we are getting better each year. We have spent a lot of time with cultural leaders and those who are considered experts in our traditional ways.

In the earlier days of our program through many intakes and analyses of patients we began to see one common denominator, and that was a grieving process that our people were going through because of a loss of culture. Whether our patients had problems with drug abuse, sex abuse, depression, suicidal tendencies, or other disorders, a core issue seemed to be this grieving.

This loss of culture manifests itself into a loss of our self identity and a loss of a good self image. These people frequently have a big void in their lives.

Once this became evident to us we realized that we had to find people in our community who had the knowledge of our culture who could work with and teach these patients. These cultural representatives have helped provide a rebirthing of those who were grieving and ultimately an improved self image.

It is important that this committee realize that the present emphasis of our program was one that came out of experience. We did not just happen to be sitting around one day and say, "Hey, let's add a cultural component to our program." For the first 3 or 4 years we had a very standard mental health practice where patients would come to our offices and discuss their problems with a psychologist for an hour if they came at all.

More frequently we would see people in jails after they had been violent or after they had abused a loved one or themselves. Now we believe we are getting into more preventative practices by seeing people before a crisis develops. But we have also been careful to incorporate modern day clinical practices and have worked very hard at designing a program and a methodology that we felt would benefit our people.

One way in which we are seeing success with this program is through a considerable reduction in attempted suicides on our reservation, which are down dramatically from where they were ten years ago. We still have much to do in this area, but we are spending less time in the emergency rooms at hospitals than we used to. Because of the community-based nature of our program and the acceptance it has in our community, people seem more willing to deal with their mental problems before they reach the boiling over point.

You can, therefore, understand why we are supportive of the legislation and particularly are encouraged by section 1(d)(7) of this bill.

Mr. Chairman, I show now quickly summarize some of our concerns with the bill that are stated in more detail in our written submission. We have attached a chart to this testimony showing the funds that are distributed in the Billings Area of IHS for mental health. We are the only tribe with a 638 contract, and yet are the lowest funding, in spite of our large population. This may indicate a bias against tribes operating this way that this committee should bear in mind.

We are also concerned with the provisions of the bill requiring that 50 percent of the proposed funding for the demonstration projects be inter-tribal consortia.

We assumed the authors' intent was to try to get the most bang for their buck, but we doubt that inter-tribals have the programmability to offer daily help to Indians. Some inter-tribals cover as much land as all the tribes from Maine to Florida, west to Louisiana. Would the committee expect an Indian in Maine to go to Nashville to get served for mental health needs?

In the Billings, Portland, and Aberdeen areas the inter-tribals that exist have no real programmatic capability. We believe funding should be made available on a needs-competitive basis in each region.

Of course, we caution the committee in that OMB will likely be looking for a reason to oppose the bill, and one of their favorite arguments is that the proposed program duplicates existing services. Be careful in structuring in this bill not to play into their hands. This may be difficult, given the inter-relationship between mental health, drugs, and alcohol dependencies and the fact that there are allegedly a number of Indian drug and alcohol programs in existence.

We ask your consideration of utilizing the existing Self-Determination Act amendments and regulations as adopted to the new regulations and requirements proposed in this bill.

We are concerned that the new mental health technical assistance office created in this bill may become a new bureaucratic bottleneck and compete for existing IHS dollars.

Finally, we have concerns about the 25 percent matching requirement. We assume the intent of the bill's author was to weed out the tribes that are really interested in this as a demonstration project from those that only want more IHS money. But we do have concerns about setting precedent. As this committee has pointed out in the past, the United States has legal responsibilities to provide health care to Indians, and we want to make sure that in the future the U.S. does not say that they will only provide 75 percent of the health care costs, and then only if tribes provide the other 25 percent.

If this section is retained, there should be clear report language pointing out that this is not precedent and it is only being allowed because this is a demonstration project.

We wish to thank the committee on their continued effort and support to improve the lives of Native Americans and their endless struggle for survival and eventual parity.

Thank you.

[Prepared statement of Mr. Irvine appears in appendix.]

Senator McCAIN. Thank you very much for your testimony and your recommendations. We will deal them with great seriousness. We appreciate your obviously careful examination of this legislation.

Governor White and Ms. Johnson, please come forward.

STATEMENT OF HON. THOMAS R. WHITE, GOVERNOR, GILA RIVER INDIAN COMMUNITY, SACATON, AZ, ACCOMPANIED BY VIOLA JOHNSON, DIRECTOR, DEPARTMENT OF HEALTH SERVICES

Mr. WHITE. Thank you, Mr. Chairman. It is an honor being here before the committee to express the views of the Pimas and Maricopas of the Gila River Indian Community.

We support the enactment of S. 1270 and view this as a significant and preliminary step taken by the Federal Government to begin to deal with the quality of mental health care provided to Indians. We have attempted to provide these professional mental health services on Gila River since 1980 through the Public Law 638 process, which Ms. Johnson will go into briefly.

The second issue that is addressed in my testimony is that the State of Arizona does not provide mental health care to Indians who need to be involuntarily placed in the Arizona State Hospital. And Arizona has refused to recognize tribal court orders placing mentally ill Indians into State hospitals or admit that Indians are citizens of the State of Arizona and, therefore, entitled to mental health services like all other citizens.

The community has made extensive efforts to inform and advise the Arizona Department of Health Services, the State Legislature, the State Hospital, and the Attorney General's Office of this problem. However, no decisions has been made. Mr. Rod Lewis will go into that briefly.

[Prepared statement of Mr. White appears in appendix.]

Senator McCAIN. Thank you, Governor White.

Ms. Johnson, do you have any comments?

Ms. JOHNSON. Yes; I would like to add a few comments.

It is important to mention that Gila River lies in two counties, Pinal and Maricopa. We also have two service units that serve the tribe—Phoenix Service Unit and Sacaton Service Unit. And, until recently, we had two separate programs—mental health and social services—that were addressing the mental health needs.

Through the 638 process we were able to combine these two programs under one administration. Our purpose in taking over, is to improve quality of care.

Until 1988 when our new hospital, Huhukam Memorial, was built, we were very short staffed. We had approximately 75 patients on a waiting list. We were a crisis oriented service.

After the summer of 1988 when the hospital opened we were able to expand these services to the point where we are meeting the ambulatory, outpatient care needs of the community.

In addition we contract with the State of Arizona for case management of the chronically Mentally Ill and Early Suicide Prevention Education.

Our staff has grown from 3.5 providers to 8, and with the fiscal year 1990 appropriations, we are expecting two additional positions for mental health. We feel that this is adequate staff.

Keep in mind that our hospital serves districts one through five and Akchin. I'm not sure what the need on the West End of the Reservation is. This is something we need to explore.

The unmet need of our community is the need for inpatient short-term and long-term psychiatric care. This is our number one priority. Individuals must have a crisis such as becoming suicidal before they are eligible for placement. This is not good practice. We'd like to do more in the area of prevention.

One of the things I heard today was that there were training dollars available. This is our number two priority. I'm not sure where the training dollars are going, we have not had access to them.

Another need is transportation. Our reservation is 65 miles long. Getting to the hospital is difficult. One of the things we hope to do with the new funding is to decentralize and take care out to the community as we do with well child and with diabetes services.

One of the topics mentioned today was the dual diagnosis and your question about whether it would be helpful to combine alcohol and drug abuse funds with the mental health funds. I think that's something that needs to be explored. When an individual presents with a primary diagnosis of substance abuse but also has psychiatric problems, what do we do with that individual often becomes a problem.

Another area to investigate would be a shared cost. Combining BIA, IHS and other resources to meet the need for inpatient psychiatric services.

The final area of concern is the limited drug formulary that IHS has available. An expanded drug formulary to address psychotropic prescriptions is needed.

I would like to just briefly mention two cases to give you an idea of what we deal with on our reservation. Case number one is a 22-year-old Pima male who presented at the emergency room at the Indian Health Service Hospital with a history of increasingly agitated bizarre, paranoid behavior. He was actively hallucinating voices. He was influenced by his illusion that someone was trying to hurt him.

Although he clearly needed inpatient psychiatric treatment, he was unwilling to go to such a facility. Attempts were made to have him petitioned for involuntary commitment through the county system; however, the admitting psychiatrist at the county facility, under the direction of the county attorney, refused to accept the patient for evaluation because the county does not have jurisdiction over reservation residents. In this case, the patient's mother was able to convince her son to voluntarily go for treatment.

In the psychiatric hospital in which he was admitted he became violent and threatening and had to be restrained on a number of occasions. Had this occurred before voluntary admission, the only alternative on the reservation would have been to put the individual in jail.

Case number two was a 6-year-old child who was in the custody of his grandmother, and he was admitted to the community youth home because of increasing violent behavior. Assistance was sought from the behavioral health clinic to determine the cause of his severe behavior problems and appropriate treatment options. His behaviors included extreme rage episodes in which he was at risk of hurting himself and others. During one such episode he put his head through a glass window.

Containment and child psychiatric assessment was deemed necessary due to the dangerousness of his behavior. An inpatient stay was approved through contract health services; however, the child was assessed as needing long-term residential management and psychiatric services. There are no funds available for this youngster's treatment.

This concludes my comments. There is information in the testimony about the commitment issues.

Senator McCAIN. Thank you very much. We appreciate both of you being here.

Dr. Dale Walker? Doctor, I notice you have a long statement. If you'd care to summarize, you are free to do so, although if you care to read all of it that's also fine with me. But, in any case, your complete statement will be made part of the record. Thank you, Doctor.

STATEMENT OF DALE WALKER, M.D., SEATTLE INDIAN HEALTH BOARD, SEATTLE, WA

Dr. WALKER. Thank you very much. I will just give a very brief statement, I hope, for you.

First of all, Senator, I would like to thank you for arranging this hearing and allowing us to testify.

My name is Dale Walker. I am a psychiatrist. I direct the Divisions of Social and Cultural Psychiatry and the Divisions of Addiction within the University of Washington's Department of Psychiatry and Behavioral Sciences. I am also a member of the Seattle Indian Health Board's Board of Directors and have been there for 12 years. Probably more importantly, I am also a member of the Cherokee Tribe, and I am a clinical research professor who has been interested in the very issues that you have brought forward in your Senate bill. I have been doing work in this area for the past 13 years.

I share your hope of improving mental health care for Indian people. Our written testimony documents the long history of problems experienced by Indian people in Seattle and other urban centers and reservations throughout the country.

We also present in our written testimony our medical board's efforts since 1970 to address these serious problems. We are always on a shoestring budget with eternal changes in policy regarding eligibility for financial support. Over the past 9 years, we have had to defend to Congress in testimony the very survival of our program because of a zero budgeting proposal for urban Indian programs.

Where do urban Indians go for health care? Well, they can't go to the Indian Health Service unless they go back to their reservation of birth or origin. In the case of my family, that would mean that I would go to Claremore, Oklahoma; my wife would to go Tahlequah, Oklahoma; and my child would go to Pocatello, Idaho.

By and large, the policies and the directives within the Indian Health Service have been very, very difficult for Indian people in years of adjustment. That's not because the Indian isn't trying to administer health care; it is because they have an incredibly restricted budget and horribly staffed situations.

You have heard lots of reports today about the circumstances, and I want to point out the tremendous effort that is made by those few people who are involved in health care within the Indian Health Service.

The difficulty is for the Indian people. The mental health problems and the treatment programs reflect the problems that are experienced in the Indian community, itself. Social issues of homelessness and unemployment are leading into a deterioration of the fabric of the American Indian family. The effects of alcoholism, domestic and general violence, suicide, depression, and untreated schizophrenia can only be solved by a broad-based, sensitive approach from the community based upon community needs.

We support the idea of Senate bill 1270 to develop and demonstrate effective mental health treatment programs, but do not want the Senate support of this issue to stop at that level. We must broadly expand the mental health services within the Indian Health Service in any other way possible in order to meet these embarrassingly unmet needs.

Now, specific to Senate bill 1270, I'd also like to make some comments. I personally believe that we should increase the funding from three to five years. The reason that I feel that way: if you are to demonstrate increased effectiveness and enhanced treatment outcome, it takes a longer period of time to do that. I would be greatly concerned at the end of three years if a large number of people were in treatment and suddenly there was a renegotiation necessary to try to find some other way to support these people.

I also request that an insurance for urban programs—they should be figured into the demonstration project formula. I think that's an important issue. I base that upon the antidrug abuse legislation monies of the last two years which urban Indian programs have not been eligible for—many monies unused.

I do support—and I think I read within the lines of 1270—that there would be an integration of alcohol and drug abuse and mental health. I do encourage you to continue that approach.

Perhaps an issue that may be difficult to propose: I would like to suggest that—I know that geographic issues and urban versus reservation versus rural settings for Indian people are very difficult issues for the Indian Health Service to grapple with. When limited resources—and believe me, I feel that $6 million, while it is a lot in my head, is a limited resource for a large number of Indian people—trying to make the determination politically or scientifically about how that is going to be done is going to be a difficult process.

I would suggest the creation of a national scientific review advisory committee or board to the Indian Health Service to assist in site selection, establishment of methodology of treatment for these programs, and assessment of the treatment process over time in order that these findings may be generalized to other programs throughout the Indian Health Service.

I was just involved in a meeting with the National Institute of Alcohol Abuse and Alcoholism on Monday and Tuesday and their council that has selected a process of doing research to try to understand what kinds of treatments work for various subtypes of alcoholic patients.

In that approach, the National Institute on Alcoholism and Alcohol Abuse has set up a national collaborative study that does something very similar to what your demonstration projects do. A thoughtful, methodological approach that would allow followup and assessment I believe would be critical to the success of this type of demonstration project.

In closing, I would like to state that we do know some facts about the treatment for mental illness. When access to care is provided, patients do participate. When mental health treatment intervention sensitive to Indian people is made, people do get better. Patients with chronic, untreated mental illness require structure, stable living arrangements, and supportive community care over long periods of time in order to gain lost years from untreated psychiatric impairment.

I think you very much for your attention.

[Prepared statement of Dr. Walker appears in appendix.]

Senator McCAIN. Thank you, Doctor Walker, for a very fine statement.

Last, and certainly not least, Ms. Susan Soule. Welcome. Thank you for your patience.

STATEMENT OF SUSAN SOULE, COORDINATOR OF RURAL AND NATIVE SERVICES FOR THE DIVISION OF MENTAL HEALTH, DEPARTMENT OF HEALTH & SOCIAL SERVICES, ON BEHALF OF MYRA MUNSON, COMMISSIONER, DEPARTMENT OF HEALTH & SOCIAL SERVICES, JUNEAU, AK

Ms. SOULE. Thank you.

I'm speaking in part for myself and in part for Myra Munson, Commissioner of the Department of Health & Social Services. My own title is Coordinator of Rural and Native Services in the Department's Division of Mental Health.

I have a cold, and I apologize. Washington is hot outside and cold inside and it is backwards. [Laughter.]

Alaska is trying something new. Our department is trying to work in partnership with the villages of Alaska to encourage the development of true community-based programs. This committee has heard a great deal about the problems facing Alaska Natives. We didn't know how to solve those problems as a department, as an agency. But we do know how to work cooperatively with people, and that's what we're trying to do with the villages.

There are two key things about our approach. One, we work in partnership with the villages. The other is that the program is truly community based.

The kind of partnership I named grows out of mutual respect and also mutual humility. We don't have the answers. We said we don't have the answers. But we respect our own ability and our own good intentions and those of the people of Alaska's villages.

Our kind of partnership has no paternalism in it. It doesn't give lip service to the value of Native human traditions while imposing regulations and funding requirements that are based on the approach and the culture of the funding agencies.

Community based, as we use it, does not mean taking psychiatrists and putting them in every village in Alaska. Fortunately, we can't afford to do that. I don't think psychiatrists are the answer. And I think in the testimony I've been listening to today we've been talking about two different things. We've been talking about major mental illnesses diagnosable in DSM3R, and we've been talking about an illness in society that has led to an illness in the spirit of human beings, and that illness of spirit expresses itself, in part, in alcohol abuse and in abusive behaviors towards self and others. Those are two different things.

One of the things we have seen in working in partnership with the villages is that village people will address both psychiatric illness and illness of the spirit if we give them the chance to do so.

We started a couple of years ago with funding from the National Institute of Mental Health, Human Resource Development Branch, to work with three villages to help them develop their own mental health needs assessment, administer it themselves, take a look at the results, and build programs for themselves based on their own findings.

We tried very hard not to impose our own beliefs and our own standards on this process, and it has taken some time.

In the village of Kake in southeastern Alaska, what people came up with when they did their needs assessment was that they were not talking to each other in the village any more, parents and children are estranged from each other, the elders are shy about offering the wisdom they have because the youth tend to be rejecting of the elders, they're cut off from each other, they're ambivalent about their own culture and tradition.

They now are putting together a program that really has two parts. One part is designed to rebuild the connections between people by having elders share their knowledge, their values, and their skills with young people.

Kake ran a little summer program this summer for five days with absolutely no outside support at all, a little bit of money from the outside, but all village people. They got the kids camping for 5 days and had elders teach them about Native food gathering, Native traditional food preservation techniques. Survival skills in the wilderness were taught both by elders and by members of the Alaska National Guard. They invited the village AA group to meet in front of the kids one evening so the kids could listen to people talk about their own experiences with alcohol abuse.

They are continuing those kinds of programs throughout the year.

The other things they are doing is working with mental health professionals to design and deliver culturally appropriate individualized case management services to the chronic mentally ill and developmentally disabled citizens of Kake.

Recently in northwest Alaska, where two other villages did a similar project, I was there when the village needs assessment folks met with the regional mental health providers who are professional and non-native. The people in those two villages felt that unresolved grief was the major source of stress and depression among children, adults, and elders in that community—grief over a vanishing culture, grief over death after death after death in the region.

They identified in their interviews with village people the kinds of things people did to help resolve their grief. They were traditional things. They were reaching out to their friends, and they were going out on the land and getting back in touch with the land.

The mental health professionals said, "Okay. Is there some way we can help and support those approaches to healing, they are likely to be effective in your village?" The village interviewer said, "Yes, let's work on that together. And, by the way, what about medication? What are the cases that medication will help in?" There is a willingness, when people have the chance, to take the best of two worlds and try to put them together.

Our biggest effort is our community-based suicide prevention program which grew out of the work of the Alaska Senate Special Committee on Suicide Prevention. When they wanted to know the problems and the programs that are likely to work, they didn't go to an official government office and ask for studies; they travelled to the smaller communities in Alaska and asked the people who lived there. And what the people said was, "Let us do it ourselves. The professionals have tried and tried and tried. We still have terrible problems, but we think we can do it."

The Alaska Senate gave our department some funds and said, "Allow the villages to define the causes of self destructive behavior for themselves. Allow them to implement their own solutions. And please put aside your tendency to separate mental health and alcohol and child abuse and sex abuse into separate issues, because the villagers told us they're part of the same issues."

We tried to do that. At the moment, we have funded 55 villages in Alaska. The average grant award is a bit under $15,000 a year.

The energy released by the program in the villages is quite remarkable. At the end of the first year we did an evaluation of the process of implementing the program, and we discovered that the villages, in terms of volunteerism and locally-raised funds, are raising 48 cents for every State dollar invested—and these villages are not wealthy places.

When we asked the villages what else can we, as a State agency, do, the overwhelming thing they wanted was, "Tell us more about the resources available for training. We want to know more. Help us bring the folks from Alkali Lake up for training."

When we asked the villages what they liked best about the program, they said they like the fact that the State is accessible. We can call up you people in Juneau and work together. We don't feel that we're enemies; we feel that we're working together.

Most of the projects are combining the best of two worlds. They are working on bringing their elders and youth together again by sponsoring traditional activities—women's clubs where women are teaching young girls how to sew skin hats. And while they sew they talk about life in the old days and they tell traditional stories. Boys and older men are building sleds. Beadwork. Ivory carving.

But they are also looking to the western world and asking to learn crisis intervention skills and basic helping skills. There have always been helpers in Alaska villages—natural helpers, people who knew how to listen, people who cared. Now these people are saying, "Can we have some extra training so we can know your ways and relate better to your systems?"

The villages are also, on their own initiative, working together in regional groupings so that they can afford more. The $15,000 is not a great deal of money. This week for three days the Athabascan villages of Huslia, Kaltag, Nulatto, and Ruby set up a training for themselves where they are bringing in mental health professionals from the Tanana Chiefs Conference. They are learning crisis intervention techniques.

The Yupik villages of Alakanuk, Emmonak, Kotlik, Marshall, and St. Mary's, in the Yukon-Kuskokwim Delta, meet regularly. Their pattern is to combine three-day workshops with evenings of cultural celebration.

Our experience with community-based programs leads us to strongly support S. 1270. Not only do Native Americans need the opportunity to develop community-based health programs, but there are particular elements in that bill which we, in Alaska, recognize as extremely strong.

The bill recognizes the need to allow the integration of mental health and alcohol services. It encourages the combining of western clinical approaches with traditional, culturally-based approaches. And it has specific provisions for technical assistance and sharing information.

We hope the time will come to implement the bill, and when it does we ask that several things be considered. A notice in the Federal Register will not reach the villages of Alaska. We ask that a real effort be made to let the villages know about the program, and the Department of Health and Social Services would be happy to assist in that.

We also ask that the request for proposals be written clearly and in nontechnical language. Communities can't respond to bureaucratic and professional jargon.

Finally, and of most importance, we ask that the program not focus on funding programs that are going to provide services for Alaska Natives and American Indians. To provide a service for someone else is to impugn their ability to help themselves.

Rather, we ask that you look to fund efforts in which people, tribes, and villages provide for themselves and define for themselves how best to do so. Please don't impose particular methods of treatment, but work, in the way the bill is written, in the way the funds are awarded, in the attitudes of the funding agency to the potential grantees, work to build a climate of trust and mutual respect and shared purpose. Because we have found that in that environment partnerships flourish and the best of both worlds can emerge.

Thank you.

[Prepared statement of Ms. Soule appears in appendix.]

Senator McCAIN. Thank you very much, Ms. Soule. I think that's an excellent testimony, and I think clearly this committee needs very badly the input concerning the special needs of Alaska Natives.

This is a followup. On the suicide prevention program, have you had any trouble finding people to participate in the program?

Ms. SOULE. No, sir. We've had 70 applications each time we have made funding available. We don't have enough money to fund all the applications we have received.

Senator McCAIN. Do you pay them? What compensation do they receive?

Ms. SOULE. The people in the villages, when they write the grants, typically write in one half-time position, and it varies from village to village anywhere from $5 to $15 an hour. The elder teachers sometimes receive stipends and sometimes work as volunteers. The recreation aspects of the program are typically staffed by volunteers.

Senator McCAIN. Thank you very much.

Dr. Wasserman, would you do me a favor and send this committee what you feel is necessary in order to provide for the needs which you articulated in your opening statement?

Ms. WASSERMAN. [Nodding yes.]

Senator McCAIN. You don't have to put a price tag on it. We have a staff here who could probably figure that out for you. But please let us know what your needs are to address these problems. We'd appreciate it if you would send them to us.

Mr. Irvine, in your program have you found any difficulties combining the cultural and clinical models? In other words, obviously your program has attempted to incorporate the cultural tradition of your tribe in these programs. Have you had any problems combining the two?

Mr. IRVINE. No; the only problem that I see that we have faced right now stems from their funding sources and this type of thing. We established what—we infused our cultures through our cultural camp to provide two cultural camps and we provide two cultural camps every summer for our cultural-based programs. And we infuse in other areas through this type of program. It is mainly through the efforts of the tribal council.

Senator McCAIN. Thank you.

Dr. Walker, I'm interested in your suggestion that mental health and alcohol and substance abuse programs be combined within the IHS. You might have noticed that I asked Doctor Johnson about that earlier. Would you elaborate just a little as to why you think that's a viable option.

Dr. WALKER. Well, the sarcastic response is that I am a psychiatrist who is in that field, and I believe it works. I'm an optimist about treatment for alcohol and drug problems, and I'm convinced that the inclusion of culture that has been mentioned here is something that works, as well. As a matter of fact, it is a critical element in recovery for any individual. In my alcohol program at the VA Medical Center we focus on cultural issues of all of our people.

I have some knowledge, also, that the Indian Health Service has begun to put those programs together. Doctor Scott Nelson is, I think, technically in charge of both of those sections. He just shook his head no. I hope he would be.

I am very much in favor of that and always have been, not because I think psychiatry should possess all of alcohol treatment.

I mentioned something a little earlier that there are sub types of alcoholics. There are alcoholic people with mental illness problems. Schizophrenia and depression, in particular, have high rates of alcohol problems. The interface and the meshing of these patients needs to be sorted out.

I think that it works best, frankly, when there is psychiatric and psychological assessment of the people who have problems. That doesn't mean that good social programs, AA, and other programs should not be closely intertwined—programs that work, as I heard the word multi-disciplinary, not just in staff, but the treatment approaches. Programs should have a variety of types of treatment because the patients are all different. They are not all alike. You can't offer them one thing. And, therefore, I think that it works better when you combine services.

So I guess you've got my view on that. I do support the combining of the two.

Senator McCAIN. Thank you.

Ms. Johnson, I share your concern about the inability of Arizona's Native Americans to get services in the State's mental hospital unless they are committed involuntarily. I assure you we'll see what we can do to rectify what clearly is discriminatory, in my view. We thank you and Governor White for being here.

Let me say that I appreciate all the witnesses here this afternoon. I recognize it has been a long hearing. I appreciate the patience of all the witnesses. I intend to, with the support of the Chairman, Senator Inouye, to mark up this bill and try and get it to the floor of the Senate before we go out of session. I think it is long overdue that we adopt a program such as this. And, as all of you are aware, if we do get this legislation enacted and funded, which is a very difficult process, it will be only the barest beginning in our attempts to address these incredible situations. The statistics were provided earlier in the hearing. They are appalling and, in my view, not symptomatic of a society which is supposed to be concerned and care for all of its citizens.

With that, I thank you again. We'll call this hearing adjourned.

[Whereupon, at 4:55 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

Additional Material Submitted for the Record

19
TRIBES
INTER TRIBAL COUNCIL
of
ARIZONA

MEMBER TRIBES
AK-CHIN COMMUNITY
CAMP VERDE YAVAPAI APACHE
INDIAN COMMUNITY
COCOPAH TRIBE
COLORADO RIVER INDIAN TRIBES
FORT McDOWELL YAVAPAI TRIBE
FORT MOJAVE TRIBE
GILA RIVER INDIAN COMMUNITY
HAVASUPAI TRIBE
HOPI TRIBE
HUALAPAI TRIBE
KAIBAB-PAIUTE TRIBE
TOHONO O'ODHAM NATION
PASCUA YAQUI TRIBE
QUECHAN TRIBE
SALT RIVER PIMA-MARICOPA
INDIAN COMMUNITY
SAN CARLOS APACHE TRIBE
TONTO APACHE TRIBE
WHITE MOUNTAIN APACHE TRIBE
YAVAPAI PRESCOTT INDIAN TRIBE

Comments to S. 1270
Mental Health Demonstration Grant Program

submitted by the Inter Tribal Council of Arizona

The Inter Tribal Council of Arizona, an organization of 19 tribal governments, appreciates the opportunity to express our support for S. 1270, the Mental Health Demonstration Grant Program.

Senator McCain, in his introductory remarks of S. 1270, stated that the current mental health service delivery system is woefully inadequate to meet the needs of American Indian communities. This factual statement is substantiated by the following:

1. The 10 bed psychiatric wing of the Gallup, New Mexico, Indian Health Service (IHS) Hospital is the only IHS in-patient psychiatric care unit in the nation.

2. 1.2% of the IHS budget is designated for mental health services.

3. The Phoenix Indian Medical Center, a four state medical referral facility, provides health care for more than 109,000 Indian people. During FY 1988, the medical center had 103,730 outpatient visits and 5,857 admissions. The Phoenix Indian Medical Center has one psychiatrist on staff to provide mental health services. It has been recommended that in order to provide adequate mental health services there should be at least one psychiatrist for every 25,000 people, one psychologist for every 5,000 people, and a medical social worker for each tribal community.

4. Tribal populations in Arizona have extremely high rates of suicide, alcohol and substance abuse. According to information from the Arizona State Department of Health Services/Department of Behavioral Health Services (DHS/DBHS) plan, the median income of American Indian clients served in the DHS/DBHS system is approximately $2,500, and the unemployment rate is 83%.

5. The State of Arizona ranks 50th in the nation in per capita mental health expenditures.

6. Only five of 20 tribal governments in Arizona have been able to access very limited State behavioral health resources through contracts.

7. The Phoenix Area Indian Health Service has not encouraged or assisted tribes to contract for mental health services. This factor as well as the minimal funds available for mental health service provision make it virtually impossible for tribes to administer programs. As a consequence only five of 20 tribal governments in Arizona have contracted for services.

There is an urgent need for in-patient psychiatric care for Indian people. For several years, tribes in Arizona have tried to negotiate with the State of Arizona for involuntary inpatient psychiatric care for tribal members at the Arizona State hospital. This problem has been on-going and although tribal and state representatives have met numerous times, no resolution has been reached. The result is that the safety of tribal communities and the individual needing psychiatric care are at risk. Tribal access to state mental health facilities is long overdue and should be addressed in this legislative proposal.

Since the level of funding is inadequate to provide a quality level of mental health care, tribes have creatively combined resources so that limited services can be provided. Tribes do access funds to provide alcohol and drug services for their communities and they can determine the services that are to be provided with the funds. However, two major problems are that there is no clear equitable allocation process for distribution of funds and for many tribes the amounts are very small.

IHS also has a small number of contracts with tribes, private counselors and clinics for inpatient and outpatient alcohol and drug rehabilitation services. Presently there are only four small facilities in Arizona that contract with IHS to provide residential services to Indian people. These facilities are located in Sacaton, Parker, Phoenix, and Whiteriver.

The Colorado River Indian Tribes Alcohol and Drug Abuse Program in Parker operates a residential treatment facility which has a capacity for eight adult men. The Indian Rehabilitation, Inc. located in Phoenix operates a 16 bed facility for Indian men and a 12 bed facility for Indian women. The White Mountain Apache Alcohol and Drug Abuse treatment facility located in Whiteriver operates a 10 bed facility of which six beds are for men and four beds are for women. The White Mountain Apache IHS hospital also has a five bed inpatient detoxification, stabilization, evaluation and referral program. The Gila River Indian Community operates a 12 bed half-way house located in Sacaton for men and women. With the exception of one position funded by IHS, this program is supported entirely with tribal funds. The Colorado River Indian Tribes and the White Mountain Apache Tribe supplement the IHS money with tribal funds so that residential services can be provided. The Indian Rehabilitation program uses state funds, grants and other donations combined with IHS monies to enable provision of services.

Voluntary in-patient psychiatric care is provided at the Gallup, New Mexico IHS hospital. Additionally, IHS has contracted with psychiatric hospitals to provide care to Indian people but this is limited to 10 days of hospitalization. Also, many of the contracting hospital staff and Indian patients experience cultural differences in relating to each other and, as a result, there are difficulties in treatment. Consequently, IHS has found that the hospitals are reluctant to renew contracts with IHS.

Mental health services for Indian people must be a priority. It is also critical, if services are to be successful, that the traditional clinical model be incorporated with treatment that is culture specific.

We applaud the recognition by Congress of the need to develop a more effective and comprehensive mental health delivery system for Indian people. We appreciate the efforts of Senators McCain and DeConcini to undertake this issue and to move forward by introducing this legislative proposal. Arizona tribes know that major modifications are needed to increase financial support for mental health programs. Based on experience, Arizona tribes also know the type of treatment needed for successful intervention and prevention. Given the existing lack of services and funds there is an overwhelming need to appropriate funds, in addition to the demonstration projects, so that more effective and comprehensive mental health delivery systems will be a reality. Without a stable source of funds to develop, maintain and expand tribal mental health programs, services for all Indian people will continue to be provided on an inconsistent crisis basis.

There are areas within the proposed legislation that we wish to address:

Page 2, line 14: Historically, the tribes have been viewed as government entities and as such, the federal government has related to tribes on a government to government basis. The Indian Self Determination Education and Assistance Act of 1975 further acknowledged the rights of tribes to manage and govern their own affairs. Given these factors and knowing that each tribe is unique in needs and resources, we cannot support the concept of preference to inter-tribal consortia. Already, tribes in Arizona work closely with one another in provison of services. There are tribes who find that it is cost-effective to contract with another tribe for services and thereby eliminate some administrative costs and other costs associated with operating a project. All tribes deserve priority consideration.

Page 2, line 22: We support the inclusion of alcohol and drug abuse treatment as services that will be delivered under this program.

Page 3, line 23: We oppose this language and recommend that the coordinating mechanisms between tribes, IHS and other Indian related-service-delivery systems be described in the proposal application.

Page 4, line 11: With regard to the provision that, "Any comments from an Area Office with respect to an application..." we recommend that tribes outline in the proposal application how coordination will occur with IHS.

Page 7, line 8: We question the establishment of another level of bureaucracy. There already exists within IHS an office of mental health. The office, staffed at an inadequate level, has been established for a number of years. What is the purpose of the existing office and how will that office coordinate with the Office of Research and Development? Will there be duplicative efforts? What amount of funds will be used to support the Office of Research and Development? Where will these funds come from? Regional meetings for the purpose of sharing information is important, but identifying and securing funds and services for tribes to solve issues and provide treatment services is a priority. The Inter Tribal Council of Arizona strongly recommends that funds be targeted for prevention and treatment projects rather than to fund an Office of Research and Development.

We appreciate the opportunity to comment on S. 1270 and support your efforts in addressing the mental health needs of American Indians.

Alaska Native Health Board

1345 RUDAKOF CIRCLE, SUITE 206 ANCHORAGE, ALASKA 99508 PHONE (907) 337-0028

September 13, 1989

Senator Frank Murkowski
United States Senate
Washington, D.C. 20510

ATTN: Bob Arnold

Dear Senator Murkowski:

The Alaska Native Health Board would like to register its strong support for your mental health demonstration grant program as proposed in S. 1270. We think it has an exciting potential for allowing tribes to take the initiative against the devastating social issues confronting us in recent years.

As you know, the Alaska Native Health Board has, for many years, promoted the community development approach to health that was so successfully "road tested" by the Alkali Lake people of British Columbia.

We believe S. 1270 would allow we in Alaska to embark on variations of the Alkali Lake theme that would work for us.

Sec. 209 (c)(2)(C)(iii) and (v), and 209 (c)(2)(d) may warrant a caution. The first two are fine as long as they aren't interpreted as meaning that the proposed program must somehow satisfy the traditional service delivery interests. That would seem to defeat the purpose of the project. The latter (D) may have the potential for stirring up "warfare," with the traditional service delivery people (many of whom may be Native American) perceiving the innovative project people as professional "heretics."

In the main, we are strongly in support of your proposed legislation, S.1270. Thank you for this opportunity to enter testimony in the public hearing record.

Sincerely,

Dennis P. DeGross

Dennis P. DeGross
Executive Director

ALEUTIAN/PRIBILOF ISLANDS ASSOC., INC.
BRISTOL BAY AREA HEALTH CORPORATION
COPPER RIVER NATIVE ASSOCIATION
KODIAK AREA NATIVE ASSOCIATION

MANIILAQ ASSOCIATION
THE NORTH PACIFIC RIM
NORTH SLOPE BOROUGH HEALTH DEPARTMENT
NORTON SOUND HEALTH CORPORATION

SOUTHCENTRAL FOUNDATION
SOUTHEAST ALASKA REGIONAL HEALTH CORP.
TANANA CHIEFS CONFERENCE
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Joan LeBeau

CHEYENNE RIVER SIOUX TRIBAL TESTIMONY

ON S. 1270

SEPTEMBER 14, 1989

Mr. Chairman and members of the Committee, my name is Dr. Emery Johnson and it is my priviledge to provide comments on S. 1270 on behalf of the Cheyenne River Sioux Tribe of South Dakota. Mr. Wayne Ducheneaux, the Tribal Chairman, had planned to testify at the hearing today, but Assistant Secretary Ed Brown is visiting the Tribal Council and reservation today, therefore he requested that I stand in for him. My testimony will be supplemented by more extensive written testimony which the Tribe will provide to the Committee for the record.

The Cheyenne River Sioux Tribe strongly supports S. 1270 and commends Senator McCain for his concern about Indian mental health. The area of mental health in Indian country is very complex and while the Cheyenne River Sioux Tribe would ideally like to see an overall and significant increase in funding for mental health programs, we also realize the constraints on the federal budget

The blue represents the thunder clouds above the world where live the thunderbirds who control the four winds. The rainbow is for the Cheyenne River Sioux People who are keepers of the Most Sacred Calf Pipe, a gift from the White Buffalo Calf Maiden. The eagle feathers at the edges of the rim of the world represent the spotted eagle who is the protector of all Lakota. The two pipes fused together are for unity. One pipe is for the Lakota, the other for all the other Indian nations. The yellow hoops represent the Sacred Hoop, which shall not be broken. The Sacred Calf Pipe Bundle in red represents Wakan Tanka—the Great Mystery. All the colors of the Lakota are visible. The red, yellow, black and white represent the four major races. The blue is for heaven and the green for Mother Earth

process. The Tribe believes that S. 1270, which would authorize funding for at least 10 demonstration programs in Indian mental health, is an important step in the right direction.

If S. 1270 is enacted into law, the Cheyenne River Sioux Tribe would apply for funding under the demonstration program to support the proposed Eagle Butte Detention Facility (jail) which they are currently in the process of developing. The Tribe is proposing to build a jail which would combine detention with treatment for substance abuse. The Cheyenne River Sioux reservation, like most others, is plagued by a high incidence of alcohol abuse. Indeed, alcohol is the single biggest killer of Indian people. Recently, the National Academy of Public Administrators documented that 95-99% of all incarcerations in Indian jails are as a result of alcohol abuse and related problems. Most Indian jails are a revolving door for alcoholics. The Cheyenne River Sioux Tribe wants to change this by providing a detoxification component and treatment at the jail, an approach has been recommended by the NAPA Report. But in order to implement the program they will require some additional funding support. Since, the Cheyenne River Sioux Detention Facility could provide a model for other tribes, it would be a suitable project for the demonstration project proposed in S. 1270.

THE NAVAJO NATION

LEONARD HASKIE
INTERIM CHAIRMAN
THE NAVAJO TRIBAL COUNCIL

IRVING BILLY
INTERIM VICE CHAIRMAN
THE NAVAJO TRIBAL COUNCIL

INDIAN MENTAL HEALTH DEMONSTRATION PROGRAM

S. 1270

TESTIMONY OF THE NAVAJO NATION BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

WASHINGTON, D.C.
SEPTEMBER 14, 1989

Honorable members of the Senate Select Committee on Indian Affairs, I am Jenny Rodgers, Acting Director of the Department of Health for the Navajo Nation. On behalf of the Navajo Nation, I would like to thank you for the opportunity to talk with you this afternoon regarding an issue of vital importance to the Nation and Native American communities, that is, the provision of mental health care.

Mental health and related issues on Indian Reservations have received very little attention to date. We find that behind just about every problem on the reservation, mental health problems are at the core. Problems such as alcoholism, sexual abuse, school dropout, teenage pregnancy and substance abuse, which arise out of and cause mental health problems, are critical areas which need to be addressed by Indian Nations with assistance from the federal government. In order to illustrate the need for mental health programs, I

Post Office Box 308 • Window Rock, Navajo Nation (Arizona) 86515 • (602) 871-4941

WOULD LIKE TO PROVIDE YOU WITH SOME BACKGROUND STATISTICS ON THE NAVAJO NATION.

AS YOU KNOW, THE NAVAJO NATION COVERS 25,000 SQUARE MILES, AN AREA ABOUT THE SIZE OF WEST VIRGINIA, SPANNING THE STATES OF ARIZONA, NEW MEXICO AND UTAH. THE NAVAJO TRIBE IS THE LARGEST IN THE UNITED STATES, WITH A POPULATION OF APPROXIMATELY 181,280. THE MEDIAN AGE OF THE NAVAJO TRIBE IS 19.3, COMPARED TO A MEDIAN AGE OF THE GENERAL U.S. POPULATION OF 30. THE NAVAJO BIRTH RATE IS APPROXIMATELY 2.7%, WHICH IS 3 TIMES THE NATIONAL AVERAGE. OUR PER CAPITA INCOME IS ABOUT $2,400, COMPARED TO THE U.S. PER CAPITA INCOME OF $12,287. 49% OF THE NAVAJOS LIVING ON THE RESERVATION HAVE INCOMES BELOW THE POVERTY LEVEL, WHILE 9% OF THE GENERAL U.S. POPULATION HAVE INCOMES BELOW THE POVERTY LEVEL. WHILE UNEMPLOYMENT IN THE UNITED STATES HAS BEEN REPORTED TO BE APPROXIMATELY 5%, NAVAJO UNEMPLOYMENT IS APPROXIMATELY 32%.

THE NAVAJO POPULATION ALSO SUFFERS GREATLY FROM A LOWER LIFE EXPECTANCY THAN THE NATIONAL AVERAGE, ALCOHOLISM AND PROBLEMS ASSOCIATED WITH CULTURAL CONFUSION AND DIFFUSION. NAVAJO YOUNG PEOPLE IN PARTICULAR SHOW SERIOUS PROBLEMS WITH SUBSTANCE ABUSE, DEPRESSION AND SUICIDAL BEHAVIOR. CONSEQUENTLY, MANY DROP OUT OF SCHOOL, HAVE DIMINISHED SELF-ESTEEM AND OFTEN A DEMORALIZED, DIM VIEW OF THE FUTURE.

THIS HOST OF PROBLEMS CREATES A GREAT NEED FOR MENTAL HEALTH SERVICES. DUE TO LIMITED RESOURCES, THE GREAT NUMBER OF PEOPLE TO BE SERVED AND THE LARGE SERVICE AREA, THE DEMAND GREATLY EXCEEDS THE SUPPLY. FOR EXAMPLE, THE INDIAN HEALTH

SERVICE (IHS) HAS A STAFF OF ONLY 45 PERSONS FUNCTIONING AS MENTAL HEALTH TEAMS TO SERVICE THE ENTIRE NAVAJO NATION. THERE ARE ONLY 3 CHILD PSYCHIATRISTS ON STAFF TO COVER THE ENTIRE RESERVATION. THE NAVAJO NATION IS SERVED BY 6 HOSPITALS, BUT THERE IS ONLY 1 IN-PATIENT MENTAL HEALTH WARD, LOCATED AT GALLUP INDIAN MEDICAL CENTER, WHICH HAS A TOTAL OF 13 BEDS. THIS WARD HAS A LONG WAITING LIST, ON WHICH SOME WAIT FOR 2 TO 3 MONTHS FOR ADMISSION. A SURVEY OF AREA PSYCHIATRISTS INDICATES THAT LESS THAN 20% OF PATIENTS NEEDING HOSPITALIZATION ARE SEEN. IN ADDITION, THERE IS A COMPLETE ABSENCE OF COMMUNITY-BASED AND CONTROLLED MENTAL HEALTH PROGRAMS SUCH AS, GROUP HOMES, HALF-WAY HOUSES, WOMEN'S SHELTERS AND CULTURALLY RELEVANT COUNSELING USING NATIVE AMERICAN HEALING. THE NAVAJO NATION HAS SOME COMMUNITY-BASED PROGRAMS IN NON-MENTAL HEALTH AREAS, EXPERIENCES UPON WHICH THE NATION CAN AND NEEDS TO BUILD UPON IN THE AREA OF MENTAL HEALTH PROGRAMS.

IN ADDITION, THERE IS AN OVERWHELMING NEED FOR MENTAL HEALTH SERVICES FOR CHILDREN. MANY NAVAJO CHILDREN ARE CONFRONTED WITH ENORMOUS PROBLEMS INCLUDING ALCOHOLISM, FAMILY VIOLENCE, SEXUAL ABUSE, TEENAGE PREGNANCY AND SCHOOL DROPOUTS. THESE PROBLEMS ARE CURRENTLY NOT BEING ADEQUATELY ADDRESSED. AS AN EXAMPLE, THE RECENT CASE OF SEXUAL ABUSE OF NAVAJO CHILDREN BY J.D. TODD, A TEACHER AT THE LOWER GREASEWOOD BOARDING SCHOOL, ALSO ILLUSTRATES THE NEED FOR COUNSELING NOT ONLY OF THE CHILDREN THAT WERE ABUSED, BUT ALSO OF SEXUAL OFFENDERS.

WE HAVE SEVERAL SUGGESTIONS FOR SOLUTIONS TO THESE PROBLEMS. FIRST, A DIRE NEED EXISTS FOR INNOVATIVE MENTAL HEALTH PROGRAMS INTEGRATING TRADITIONAL NATIVE HEALING WITH WESTERN MEDICINE, WHERE PATIENTS CAN RECEIVE THE BEST OF THE TWO METHODOLOGIES WORKING HAND-IN-HAND. MANY TRADITIONAL NATIVE AMERICANS HAVE DIFFICULTY RESPONDING TO WESTERN MEDICAL TECHNIQUES PARTICULARLY WHERE CONFIDENCE, OPEN COMMUNICATIONS, TRUST AND UNDERSTANDING ARE INTEGRAL PARTS OF THE HEALING PROCESS. THEREFORE, NOT ONLY SHOULD TRADITIONAL AND WESTERN METHODOLOGIES BE INTEGRATED, BUT IN ADDITION, NON-INDIAN MEDICAL PERSONNEL SHOULD BE TRAINED AND FAMILIARIZED WITH ASPECTS OF NATIVE AMERICAN MEDICINE, CULTURE AND TRADITIONS, SO THAT THEY MAY BETTER EMPATHIZE WITH AND TREAT THEIR INDIAN PATIENTS. THE SPORADIC, NON-FORMAL APPROACH NOW USED BY SOME HOSPITALS COMBINING TRADITIONAL NATIVE AMERICAN AND WESTERN APPROACHES SHOULD BE FORMALLY INTEGRATED INTO THE MENTAL HEALTH SYSTEM.

THE SECOND IMPORTANT ASPECT TO CONSIDER IS THAT THESE NEW MENTAL HEALTH INITIATIVES NEED TO BE ACCOMPLISHED BY NATIVE AMERICANS THEMSELVES. THE EXTENDED FAMILY AND CLAN RELATIONSHIPS AND THE STRONG TRADITIONAL TIES THAT BIND NAVAJOS TOGETHER CAN BE USED TO BUILD A PROGRAM WHICH NAVAJOS CAN RELATE TO AND TRULY BENEFIT FROM. POSITIVE, INNOVATIVE MENTAL HEALTH PROGRAMS ADMINISTERED BY NATIVE AMERICANS WOULD GREATLY CONTRIBUTE TO INDIAN SELF-DETERMINATION.

I COMMEND THE COMMITTEE AND SENATOR MCCAIN FOR BEING SENSITIVE TO THESE CONSIDERATIONS AND FOR RECOGNIZING THE DIRE NEED THAT EXISTS FOR EXPLORING MENTAL HEALTH SERVICES OPTIONS.

S. 1270 PROVIDES OPPORTUNITIES TO CREATE INNOVATIVE, COMMUNITY-BASED PROGRAMS WHICH MAY COMBINE MODERN CLINICAL APPROACHES WITH CULTURALLY-RELEVANT INDIAN METHODS OF TREATMENT. WE WELCOME THE OPPORTUNITY TO EXPLORE VARIOUS MENTAL HEALTH CARE DELIVERY SYSTEMS AND ENCOURAGE THE COMMITTEE TO ENSURE THE FUNDING OF SUCH PROGRAMS UPON THE COMPLETION OF EFFECTIVE DEMONSTRATION PROJECTS.

THE NAVAJO NATION WOULD LIKE TO MAKE SOME SUGGESTIONS FOR MODIFICATIONS TO S. 1270. FIRST, WE WOULD SUGGEST THAT THE GRANTS CONTEMPLATED BY THIS MEASURE BE MADE AVAILABLE TO TRIBES AND TRIBAL CONSORTIA THROUGH THE INDIAN SELF-DETERMINATION AND EDUCATION ASSISTANCE ACT, AS AMENDED (SECTION 103(E)(2)), IF THE TRIBE OR TRIBAL ORGANIZATION SO CHOOSES THAT APPROACH. THIS IS A GRANT PROGRAM FAMILIAR TO BOTH THE TRIBES AND TRIBAL ORGANIZATIONS, AS WELL AS THE IHS, WHICH PROVIDES THE MECHANISM FOR MAKING THE CONTEMPLATED GRANTS.

IN ADDITION, IF FINAL APPROVAL AUTHORITY FOR GRANT EXPENDITURES RESTS WITH THE IHS ON MENTAL HEALTH PLANS DESIGNED BY TRIBES, THE RESPECTIVE MENTAL HEALTH SERVICES EFFORTS MAY BE HAMSTRUNG WITH UNNECESSARY RED TAPE, PARTICULARLY WITH INNOVATIVE PROJECTS INVOLVING TRADITIONAL HEALING, WHERE IHS HAS LIMITED EXPERIENCE. THEREFORE, THE FINAL AUTHORITY FOR APPROVAL FOR DESIGN, IMPLEMENTATION AND EXPENDITURE OF GRANT FUNDS SHOULD REST WITH THE TRIBES AND TRIBAL HEALTH AUTHORITIES.

FINALLY, THE BILL REQUIRES THE IHS TO PROVIDE TECHNICAL ASSISTANCE TO INDIAN TRIBES. HOWEVER, IT IS UNCLEAR WHAT KIND OF TECHICAL ASSISTANCE WOULD BE PROVIDED. WOULD IT INCLUDE TRAINING? ADDITIONAL EQUIPMENT? OUR CONCERN IS THAT

THESE RESOURCES PROVIDE DIRECT BENEFITS AND NOT JUST BECOME AN ADDITIONAL IHS ADMINISTRATIVE COST.

IN CONCLUSION, THE NAVAJO NATION STRONGLY SUPPORTS S. 1270. WE APPLAUD THE COMMITTEE FOR TURNING ITS ATTENTION TO THE ISSUE OF MENTAL HEALTH. SUCH EFFORTS COMPLEMENT THOSE LAUNCHED BY THE BUSH ADMINISTRATION TO COMBAT THE NATION'S DRUG PROBLEM. I THANK YOU FOR PERMITTING US THE OPPORTUNITY TO SUPPLY YOU WITH OUR VIEWS AND WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE OR TO SUBMIT ADDITIONAL INFORMATION AS NECESSARY.

By the MISSISSIPPI BAND OF CHOCTAW INDIANS
CHOCTAW BRANCH PO BOX 6010
Philadelphia, Mississippi 39350

Thank you, Mr. Chairman. My name is Nell Rogers and I am a planner for the Mississippi Band of Choctaw Indians. With me is Greta Holly, director of the Choctaw Rehabilitation Services, a comprehensive assessment, treatment, job skills training, and job placement program for mentally and physically disabled Choctaw adults.

On behalf of Tribal Chief Phillip Martin, we are grateful to have the opportunity to speak in favor of S. 1270, a very positive and creative bill -- one which addresses, in a sensible manner, a profound problem for the Mississippi Choctaws and one which is likely to be equal seriousness for many other tribes.

In our remarks, we will, first, outline the need for this proposed legislation -- from the context of the experience of the Mississippi Choctaws. We will describe what the tribe has done, using a 'patch-work' arrangement of funds, to partially address the problem, concluding with the importance of this legislation to that effort.

The Mississippi Choctaws have worked with purpose to achieve community and economic development, applying diligent attention to developing the tribe's only resource -- its people and their will to work. In this regard, the tribe has been very successful, creating nearly 1,400 private sector jobs on the reservation since 1979, with nearly 70 per cent of these jobs held by tribal members. The unemployment rate has been dramatically reduced and only five per cent of household income on the reservation now comes from public assistance.

While the tribe is proud of its record, one segment of the population -- the mentally ill and the mentally and physically handicapped -- were unable to benefit from this new availability of employment due to their untreated conditions and their need for specialized training and other services which would make employment possible. For these tribal members, this void in appropriate mental health services has had grave consequences: they have known only a lifetime of limitation, one marked by inactivity, infirmity, and dependency.

The tribe set out three years ago to find a means of treatment and rehabilitation which would enable these individuals to become more functional and engaged in a productive life. In many cases, low educational attainment, damage from long-term alcohol abuse, physical disabilities, and unmet mental health needs surfaced as the primary barriers to the attainment of this goal. Efforts to approach these problems separately had not been successful. In response, we began work on a service plan which would assure centralized treatment of multiple problems. We found, not surprisingly, that there was no agency or program with either the funds or the inclination to support comprehensive, yet alternative approaches to treatment, care, training, employment, and independent living for the mentally disabled.

Choctaw's only solution was to use funds from several sources, establishing Choctaw Rehabilitation Services in October, 1987. This program is one which varies from traditional mental health programs but it is one which is working with marked success for its clients.

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Mr. Chairman, I am Greta Holly. I, too, am very pleased to be able to testify in support of S. 1270 since I believe that our success with a different kind of program stands as a strong indicator of the need for demonstration grants such as those proposed in the bill.

Rather than limiting itself to simply counseling as a means of dealing with the conditions of the clients, our program provides a full range of services: psychological counseling and therapy, psychometric assessment, vocational evaluation and counseling, case management, work adjustment training, job skills training and placement, and follow-up counseling and post employment services. Our staff and the program services are provided from a number of sources: the Rehabilitation Services Administration and the Indian Vocational Education Program in the U.S. Department of Education and the EARN (Employment Assistance Readiness Network) Demonstration Program sponsored by the Bureau of Indian Affairs social services program. In addition, our clients receive literacy and GED education from the Choctaw Adult Education Program, health care from the Choctaw Health Center, psychological counseling and evaluation from Choctaw Mental Health, and some physical restorations from state rehabilitation services.

As a direct result of these services this year, 55 adults -- most of whom had never been employed -- have been placed and remain in competitive employment. We are very proud of this accomplishment.

Once the program began operation, we found that the extent of need was far greater than anticipated. We are serving 88 clients now; however, we have a waiting list of 312, most of whom have already been evaluated and found eligible for services. Over 70 per cent have mental disabilities which include retardation, alcohol and substance abuse damage, emotional disturbances, and learning disabilities. At least 50 per cent of our clients have an alcohol or substance abuse problem as a secondary disability which can undermine the rehabilitation effort unless that, too, is addressed and controlled.

My experience with clients who have mental problems has been that the most important areas which must be addressed are those of helping the clients find a purpose in life, develop feelings of self-worth, and develop independence and self-sufficiency. The most effective way that we have found to address these issues has been to take a holistic approach. An integral part of that is assisting clients with employment goals. As part of our program, we provide job skills training in three areas:

1. Industrial training - which provides training in industrial assembly jobs and general work skills transferable to many vocations;

2. Horticultural training - which provides training in general work skills and specific jobs skills needed for plants, vegetable, and fruit production and for the marketing of these products. (This type of training is very successful for those clients who are unable to adapt to the more complex work setting of a manufacturing plant.)

3. Field training - which provides training at a variety of businesses and industries, both on and off the reservation. This component provides greater options for employment development for the client.

We also provide sheltered employment when it is determined that chronically mentally ill clients cannot function in a competitive environment. These individuals are given the option of entering sheltered employment, usually in a satellite industrial site or at the greenhouse.

We knew, however, that simply providing this job skills training for the mentally disabled was not enough. This had already been attempted by our vocational training program. For those clients with mental problems, this approach falls short of providing them with the skills to keep a job once attained and to cope with daily life situations. Our clients receive many additional services: thorough assessments, followed by setting reasonable goals and objectives and developing an individualized plan for each person; job skills training for those for whom this is appropriate; work adjustment training which helps the client develop independent living skills and proper work habits and attitudes; and other services aimed at eliminating barriers to employment and productive community living. Extensive follow-up and related post-employment services are provided to insure continued vocational and personal success.

It is important to note here the importance of financial support for clients who are participating in our treatment/rehabilitation effort. For us, the BIA EARN demonstration program is meeting a longstanding need for incentive stipends for those who enter training. (In the absence of these stipends, our clients who are in job training would only receive $115 per month in general assistance and TWEPT payments. This would not be enough to pay for their transportation, work clothing, and lunches.) The EARN project also provides a social worker who assists clients in solving transportation, home and family problems in a manner which will foster independent problem solving by the client. A work adjustment counselor aids them on work habits and interpersonal skills development.

Because we have found that it is important to speak to all aspects of the client's life in preparation for independent living, I am especially pleased to see that this bill proposes to address the previously misunderstood and sometimes ignored mental disabilities of American Indians which can surface and resurface, causing havoc both at home and at work. The most effective way to combat this problem is to provide adequate evaluation to determine the nature of the client's mental health needs; implement a treatment plan which addresses each of the client's needs; to provide vocational rehabilitation services which will enable the client to be successful in a career; to implement a maintenance plan which will provide timely interventions when necessary, not when it's too late, and to involve the client in all planning with respect to his or her life. It is imperative that each client have a complete and full understanding concerning the nature of his or her mental health needs so that there can be some individual responsibility assumed for seeing that the treatment and maintenance plans are followed. It is clear that S. 1270 would allow tribes and tribal organizations to began to develop and test similar -- or other equally appropriate approaches to mental health care in their communities.

I would like to conclude with some recommendations and a word of caution. I believe that the activities allowed under the demonstration grants should include incentive stipends for training for any tribal members who have successfully completed an alcohol or substance abuse treatment plan and who want to participate in training -- either in a vocational program or on-the-job training. It is vital to an individual's alcohol/substance abuse rehabilitation that training and employment opportunities be made available immediately upon completion of treatment, so that discouragement and previously unproductive ways of behavior do not recur.

A growing problem for us is housing for the chronically mentally ill. A number of our clients, especially the most seriously disabled, have no place to live or live in an undesirable setting. Most often they are single adults with no family or they have lost their families through adverse behavior. There is great need for the legislation to support an examination of supervised living arrangements for the mentally ill, thereby avoiding institutionalization and assuring a community-based approach.

Right now, the options for caring for this population are marked by lack of funding, narrow focus, and a failure to develop comprehensive service plans. S. 1270, as written, could answer these shortfalls. However, there must be provision for the continuation of these demonstration programs if they are found to be effective. One of the most damaging aspects of program development for Indian tribes is that of inconsistent funding and policy. Indian populations -- more than any other in this country -- have repeatedly faced the disruptions of service programs due to policy changes. In the case of the mentally disabled, whose treatment and recovery require consistency, these changes are especially harmful. They do not have the flexibility and resources to move on to other options and their services must be continued on a daily basis.

We are particularly aware of the necessity for establishing and holding to a policy of consistency because, in a few weeks, our funding from the Rehabilitation Services Administration will end. This supports all our professional staff for evaluation, counseling, placement, and sheltered employment. In another year, the BIA EARN project will end, unless both the Congress and the BIA agree to its continuation. State and federal programs which serve the non-Indian mentally ill and mentally disabled are not generally subject to such funding uncertainties. I believe that S. 1270 can become the means through which Indian tribes can develop, test, and establish permanent programs for these vulnerable populations.

STATEMENT OF

EVERETT R. RHOADES, M.D.

DIRECTOR

INDIAN HEALTH SERVICE

Thank you, Mr. Chairman. I am pleased to be here today to talk with you about the IHS mental health delivery system and to comment on the proposed legislation to create a mental health demonstration program and technical assistance center.

Despite the many strengths of Indian people and their families, there is a high incidence of family disruption, violence, and physical, emotional, and sexual abuse of children and adults in Indian communities. As one example, the incidence of suicide in young adult Indian males is 2-3 times the national average. We in the IHS view this situation with increasing concern, and we are developing ways to meet the current need. Before discussing this, I would like to describe our present program.

The mission of the IHS mental health program is to provide access for all American Indian/Alaska Native persons to mental health services which are appropriate to the nature and severity of the mental illness, of high quality, and sensitive and responsive to the cultural values of the individual, family, and community.

At the community level, delivery of mental health services is a responsibility of the local service unit, operated either directly by IHS (80% of service units) or by a tribally-administered program (20% of service units). Tribes are increasingly assuming the responsibility for operating mental health service programs pursuant to the provisions of the Indian Self-Determination Act, P.L. 93-638.

The most common local mental health program model is an outpatient service staffed by one or more mental health professionals, often with the assistance of a local American Indian/Alaska Native mental health technician.

On-call emergency mental health services are routinely provided outside of usual clinic or hospital hours. Consultation by IHS and tribal mental health personnel is provided to medical staff and to other service unit and/or tribal programs. Specialized mental health services for populations such as children and the elderly are minimal to nonexistent.

Inpatient services are available through several mechanisms in almost all service units. Some IHS hospitals can accommodate non-violent psychiatric patients for a few days. More commonly, inpatient services are provided under contract with local psychiatric units or private psychiatric hospitals. At times, emergency hospitalizations and long-term care are provided by state mental hospitals. The Indian Health Service operates two short-term psychiatric hospital inpatient units: a 14 bed unit is available at the Gallup Indian Medical Center, and a 9 bed unit in the Indian Health Service Hospital in Rapid City, South Dakota.

Native healers provide services in most American Indian and Alaska Native communities. These services and Western methods tend to complement each other in the psychological care for more serious mental disorders, and are often sufficient to resolve situations involving emotional distress.

In many Areas, state or local community mental health programs also provide services to Indian persons with emotional problems. Diagnostic observation, transitional living, and child residential mental health care must be obtained from local or state programs where such resources are available.

In most Areas, primary funding for mental health services for American Indian and Alaska Native people is provided through the line-item categorical appropriation for mental health services in the IHS budget. In fiscal year 1989, this appropriation was just over $13 million. The Congress appears ready to increase this amount by $5 to $7 million in the FY 1990 budget, as proposed by the Senate and House, respectively.

Some service units use other sources of funds to purchase mental health services. These include hospital and clinic (general health) funds or contract health service funds. In addition, states and local governments often provide services to Indian persons through local community mental health programs. However, in South Dakota, IHS is charged for State hospital services pursuant to a 1978 federal court decision known as White vs. Califano. This decision is in conflict with the long established doctrine that IHS is a last resort payor of service.

As of April 1989, the IHS identified 236 staff funded by mental health categorical funds. Of the 236 staff, 198 are direct treatment staff, while 38 are administrative or clerical. The 198 service unit staff include 45 mental health technicians, 52 social workers, 37 psychologists, 22 psychiatrists, 7 psychiatric nurse specialists and 32 members of other disciplines (social service aides, medical anthropological staff). Of these direct treatment staff, 190 are employed by the Indian Health Service and 46 are employed by tribal organizations. Some additional staff are employed by tribes through 638 contracts or from other tribally obtained resources. Of the 198 direct treatment staff, 109 are Native Americans. Only 17 are trained to deliver services to children or adolescents. The 198 employees are spread across 132 Service Units, for an average of about 1.5 mental health direct treatment personnel per IHS Service Unit.

I would now like to turn to the actions that IHS has been taking and proposes to take, to increase and improve mental health services for Native American people.

Currently, IHS national and Area mental health staff are working closely with consultants and local Service Units to improve the current program. Activities now include:

- The development of a draft National American Indian/Alaska Native Mental Health Plan, which is currently circulating widely in the field for comment. The plan establishes services to children and adolescents as the priority for service and calls for an increase in the number of mental health staff in order to meet minimal levels of need for mental health services (nationally accepted ratios of 1 primary provider per 2,000 persons).

- Mental health consultation to tribes, IHS and other field personnel regarding strategies for prevention of suicide and other forms of violent behavior, and for development of child and adolescent mental health programs. This assistance is provided by the Special Initiatives Team which was established in 1986.

- A quality assurance program, which includes reviews of mental health programs for adherence to IHS mental health standards.

- The implementation of a collaborative agreement between IHS Mental Health and Substance Abuse programs to provide for mutual support and collaboration on the many cases which require specialized care from both disciplines.

- Cooperative action with other agencies in providing services to special groups; such agreements with the American Indian Headstart Programs and the Bureau of Indian Affairs have enhanced services to preschool-aged children and to victims of sexual abuse through the Child Protection Teams.

Mr. Chairman, in addition to these current efforts, I am working closely with other department officials to strengthen our approach to the mental health problems which Indian people and Alaska Natives encounter. I believe our effort is going to be very comprehensive, targeting all segments of the Indian population, including both prevention and treatment efforts, and emphasizing close cooperation between the federal government and the tribes.

With regard to the provisions of S. 1270, to create at least ten mental health demonstration programs and to establish a technical assistance office, I believe that our existing legislative authority is sufficient to undertake these activities, although I feel that this would not be the best use of our resources. I question the usefulness of demonstrations at this stage of our mental health program, and I believe our future approach will be more broad. In the coming months I will be eager to share our plans with the Committee and to work with you towards achievement of our common goals: a comprehensive, well-organized, and well-managed mental health delivery system carefully structured to meet the needs of the people we serve.

Mr. Chairman this concludes my prepared statement and I would be glad to answer any questions you might have.

Table 2.1
IHS Population by Area
1980-1990

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
All Areas	828,609	849,315	870,963	902,627	937,043	961,884	986,881	1,012,872	1,039,841	1,076,417	1,105,486
(Growth Factor)	–	(2.50)	(2.55)	(3.64)	(3.81)	(2.65)	(2.60)	(2.63)	(2.66)	(3.52)	(2.70)
Aberdeen	63,253	64,959	66,731	68,571	70,470	73,343	75,396	77,514	79,702	81,960	84,280
Alaska	64,047	65,780	67,586	69,503	71,520	73,842	75,861	78,179	80,600	83,120	85,737
Albuquerque	46,610	47,889	48,830	50,003	51,216	52,473	53,786	55,108	56,485	58,180	60,067
Bemidji	42,686	43,653	44,681	45,768	46,908	48,102	49,364	50,681	52,052	54,237	55,742
Billings	35,708	37,151	38,627	40,138	41,683	42,855	44,075	45,341	46,644	47,984	49,368
California	65,757	67,091	68,597	70,266	72,100	74,119	76,298	78,645	81,160	83,845	86,699
Nashville	26,731	27,174	28,114	30,303	35,419	35,533	36,073	36,632	37,205	42,883	43,545
Navajo	145,162	149,198	153,350	157,827	162,025	166,543	171,183	175,943	180,824	185,822	190,946
Oklahoma City	172,636	176,353	180,231	185,048	189,276	193,686	198,257	203,003	207,820	213,003	218,262
Phoenix	74,020	76,308	78,221	80,263	82,424	84,715	87,129	89,668	92,335	95,641	98,569
Portland	75,760	77,384	79,051	87,801	96,224	98,688	100,836	103,034	105,287	107,589	109,960
Tucson	16,230	16,576	16,944	17,336	17,749	18,185	18,643	19,124	19,627	20,154	20,702

NOTE: The IHS Service population included the Reservation States of Connecticut, Rhode Island, and Texas in 1983, Alabama in 1984, Massachusetts in 1989.
SOURCE: Estimated Indian and Alaska Native Service Population by Area based on 1977-1986 vital events.

Chart 2.3
Population by Age and Sex, 1980 Census

The Indian male and female populations are younger than the corresponding male and female populations for the U.S. All Races.

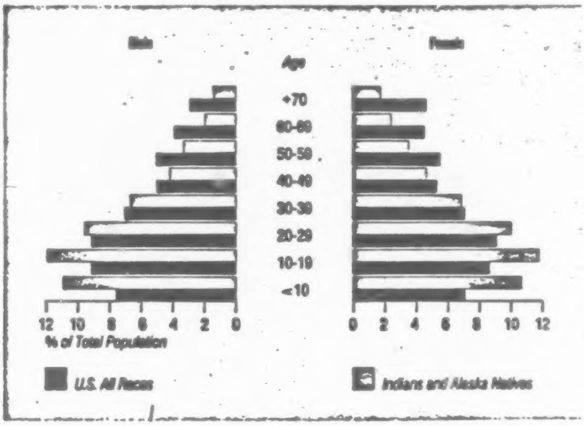

Table 2.3
Age and Sex
Percent Distribution

American Indians and Alaska Natives, Reservation States and U.S. All Races 1980 Census Data

	Indian & Alaska Native		U.S. All Races	
	Male	Female	Male	Female
Total	49.325	50.675	48.578	51.422
Under 10 years	10.782	10.502	7.480	7.127
10–19 years	11.767	11.508	8.859	8.537
20–29 years	9.451	9.645	8.980	9.036
30–39 years	6.445	6.779	6.859	7.857
40–49 years	4.248	4.585	4.886	5.148
50–59 years	3.208	3.486	4.801	5.386
60–69 years	2.024	2.343	3.784	4.345
70 years and over	1.421	1.847	2.828	4.575

NOTE: Percentages may not sum to totals due to rounding.

Chart 2.4
Population by Age, 1980

For Indians, 32% of the population was younger than 15 years, and 5% was older than 64 years. For the U.S. All Races population, the corresponding values were 23% and 11%, respectively.

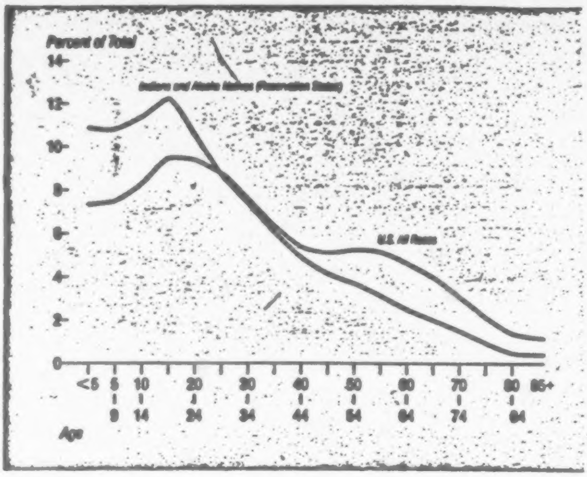

Table 2.4
Number and Percent Age Distribution

American Indians and Alaska Natives, Reservation States and U.S. All Races 1980 Census Data

	Indian & Alaska Native		U.S. All Races	
Total	Number 1,303,193	Percent 100.000	Number 226,504,825	Percent 100.000
Under 5 years	140,111	10.751	16,344,407	7.216
5–9 years	136,989	10.512	16,697,134	7.372
10–14 years	145,673	11.178	18,240,919	8.053
15–19 years	157,612	12.094	21,161,867	9.343
20–24 years	135,587	10.404	21,312,557	9.409
25–29 years	113,271	8.692	19,517,672	8.617
30–34 years	96,621	7.414	17,557,857	7.752
35–39 years	75,710	5.810	13,963,008	6.165
40–44 years	62,363	4.785	11,668,239	5.151
45–49 years	52,496	4.029	11,088,383	4.895
50–54 years	46,654	3.580	11,708,924	5.169
55–59 years	40,604	3.116	11,614,054	5.128
60–64 years	30,928	2.373	10,085,711	4.453
65–69 years	25,981	1.994	8,780,844	3.877
70–74 years	18,204	1.397	6,796,742	3.001
75–79 years	12,577	0.965	4,792,587	2.116
80–84 years	6,427	0.493	2,934,229	1.295
85 years & over	5,385	0.413	2,239,721	0.989
Median Age	22.6		30.0	

NOTE: Percentages may not sum to totals due to rounding.

Chart 4.19
Age-Adjusted Suicide Death Rates

The age-adjusted suicide death rate for American Indians and Alaska Natives has decreased 29% since its peak in 1975 (of 21.2 deaths per 100,000 population. The Indian rate for 1986 was 15.0 compared to the U.S. All Races rate of 11.9.

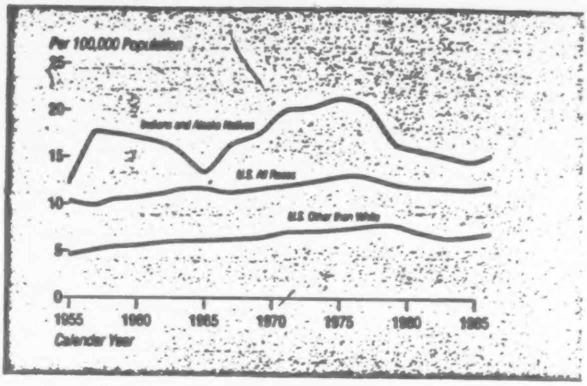

Table 4.19
Suicide Deaths and Mortality Rates

American Indians and Alaska Natives and Selected U.S. All Races, 1955–1986 Age-Adjusted Rate per 100,000 Population

Calendar Year	Indian & Alaska Native Number	Indian & Alaska Native Rate	U.S. All Races Number	U.S. All Races Rate	U.S. Other than White Rate	Ratio Indian to: U.S. All Races	Ratio Indian to: U.S. Other than White
1986	211	15.0	30,904	11.9	6.8	1.3	2.2
1985	204	14.1	29,453	11.5	6.7	1.2	2.1
1984	181	12.9	29,286	11.6	6.6	1.1	2.0
1983	196	14.7	28,295	11.4	6.4	1.3	2.3
1982	178	13.6	28,242	11.6	6.4	1.2	2.1
1981	191	15.5	27,596	11.5	6.6	1.3	2.3
1980	173	14.1	26,869	11.4	6.7	1.2	2.1
1979	186	16.1	27,204	11.7	7.9	1.4	2.0
1978	150	14.0	27,294	12.0	7.4	1.2	1.9
1977	199	20.5	28,681	12.9	7.8	1.6	2.6
1976	168	17.9	26,832	12.3	7.6	1.5	2.4
1975	180	21.2	27,063	12.6	7.5	1.7	2.8
1974	148	18.0	25,683	12.2	7.2	1.5	2.5
1973	149	19.8	25,118	12.0	7.2	1.7	2.8
1972	138	18.5	25,004	12.1	7.5	1.5	2.5
1971	135	19.9	24,092	11.9	7.0	1.7	2.8
1970	105	17.9	22,630	11.8	6.5	1.5	2.8
1969	94	16.8	22,364	11.3	6.3	1.5	2.7
1968	80	17.5	21,372	11.0	5.7	1.6	3.1
1967	94	16.2	21,325	11.1	6.1	1.5	2.7
1966	94	15.2	21,281	11.2	6.1	1.4	2.5
1965	85	12.9	21,507	11.4	6.1	1.1	2.1
1964	82	15.8	20,588	11.0	5.6	1.4	2.8
1963	86	15.6	20,825	11.3	6.0	1.4	2.6
1962	89	16.9	20,207	11.1	5.6	1.5	3.0
1961	81	16.7	18,999	10.5	5.6	1.6	3.0
1960	87	16.8	19,041	10.6	5.4	1.6	3.1
1959	87	17.0	18,633	10.6	5.5	1.6	3.1
1958	81	18.7	18,519	10.5	5.1	1.8	3.7
1957	88	17.6	16,632	9.8	4.7	1.8	3.7
1956	46	12.5	16,727	9.7	4.4	1.3	2.8
1955	39	11.9	16,760	9.9	4.3	1.2	2.8

NOTE: Estimated population methodology for the Indian population revised in 1976. Maine, New York and Pennsylvania included as Reservation States beginning in 1979, Connecticut, Rhode Island and Texas in 1983 and Alabama in 1984. Decennial Census population counts used for 1960, 1970 and 1980.

Table 4.20

Suicide Mortality Rates by Age and Sex

American Indians and Alaska Natives, 1984-1986 and U.S. All Races, 1985
Rate per 100,000 Population

	Indian & Alaska Native		
	Both Sexes	Male	Female
Under 5 years	–	–	–
5–14 years	1.7	2.3	1.1
15–24 years	24.4	40.9	7.8
25–34 years	26.0	45.2	7.5
35–44 years	19.1	30.4	8.4
45–54 years	10.8	18.2	3.5
55–64 years	9.2	16.9	3.2
65–74 years	7.5	13.5	2.5
75–84 years	3.2	7.3	0.0
85 years +	5.6	14.0	0.0

	U.S. All Races		
	Both Sexes	Male	Female
Under 5 years	–	–	–
5–14 years	0.8	1.2	0.4
15–24 years	12.9	21.4	4.4
25–34 years	15.2	24.5	5.9
35–44 years	14.6	22.3	7.1
45–54 years	15.6	23.5	8.3
55–64 years	16.7	26.8	7.7
65–74 years	18.5	33.3	6.9
75–84 years	24.1	53.1	6.8
85 years +	19.1	55.4	4.6

	U.S. Other than White		
	Both Sexes	Male	Female
Under 5 years	–	–	–
5–14 years	0.5	0.7	0.3
15–24 years	8.9	16.1	2.6
25–34 years	11.0	19.3	3.4
35–44 years	8.3	13.6	3.8
45–54 years	7.5	12.3	3.5
55–64 years	7.0	12.3	2.8
65–74 years	8.6	16.1	3.7
75–84 years	8.7	18.3	4.5
85 years +	6.0	11.7	3.2

NOTE: – Represents zero.

Chart 4.20

Suicide Death Rates by Age and Sex Indians and Alaska Natives (1984–86)

The age-specific suicide death rate (1984–1986) for Indian males was higher for all age groups in comparison to Indian females. The Indian male rate exceeded 40.0 deaths per 100,000 population for age groups 15 through 34.

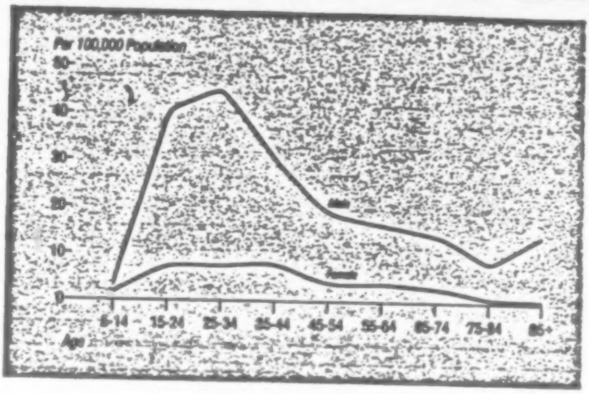

Chart 4.21

Age-Adjusted Homicide Death Rates

The age-adjusted homicide death rate for American Indians and Alaska Natives falls between the rates for the U.S. Other than White and U.S. All Races populations. In 1986, the Indian rate was 16.3 deaths per 100,000 population compared to 27.2 for the U.S. Other than White and 9.0 for the U.S. All Races populations.

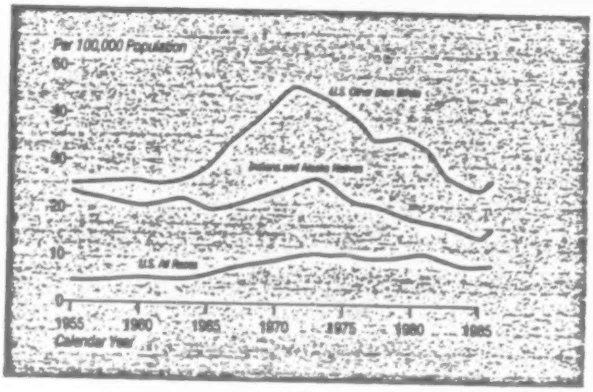

Chart 5.7

Leading Causes of Hospitalization, FY 1988 IHS and Contract General Hospitals

In FY 1988, 24.5% of all discharges from Indian Health Service and contract general hospitals pertained to "obstetric deliveries and complications of puerperium and pregnancy." This was followed by "respiratory system diseases" at 11.6%.

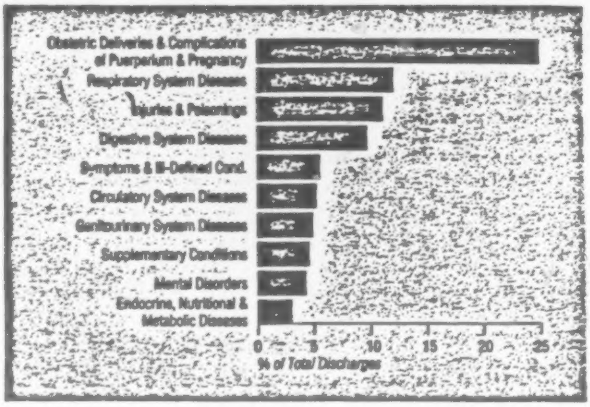

Table 5.7

Ten Leading Causes of Hospitalization for GM&S Patients FY 1988

Indian Health Service Direct and Contract General Hospitals

	Number of Discharges			Percent Distribution		
Diagnostic Category	Combined	IHS	Contract	Combined	IHS	Contract
All Categories	91,359	75,454	15,905	100.0	82.6	17.4
				100.0	100.0	100.0
Obstetric deliveries and complications of puerperium & pregnancy	22,422	19,129	3,293	24.5	25.4	20.7
Respiratory system diseases	10,572	9,087	1,485	11.6	12.0	9.3
Injuries & poisonings	9,974	7,269	2,705	10.9	9.6	17.0
Digestive system diseases	8,770	7,093	1,677	9.6	9.4	10.5
Symptoms & ill-defined conditions	4,896	4,067	829	5.4	5.4	5.2
Circulatory system diseases	4,854	3,601	1,253	5.3	4.8	7.9
Genitourinary systm diseases	4,787	3,919	868	5.2	5.2	5.5
Supplementary conditions	4,213	3,993	220	4.6	5.3	1.4
Mental disorders	3,830	3,002	828	4.2	4.0	5.2
Endocrine, nutritional & metabolic diseases	3,193	2,750	443	3.5	3.6	2.8
All other	13,849	11,544	2,305	15.2	15.3	14.5

SOURCE: Annual Reports 2C and 3I.

Chart 5.8

Leading Causes of Hospitalization for Males

For males, 17.9% of all discharges (FY 1988) from Indian Health Service and contract general hospitals pertained to "injuries and poisonings." This was followed by "respiratory system diseases" (16.3%), and "digestive system diseases" (12.0%).

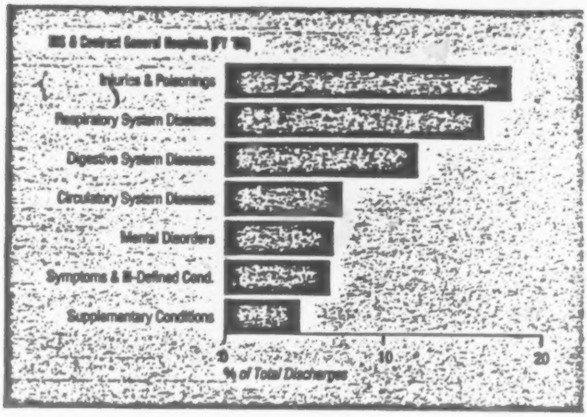

Chart 5.9

Leading Causes of Hospitalization for Females

For females, 38.9% of all discharges (FY 1988) from Indian Health Service and contract general hospitals pertained to "obstetric deliveries and complications of puerperium and pregnancy." This was followed by "respiratory system diseases" (8.8%), and "digestive system diseases" (8.2%).

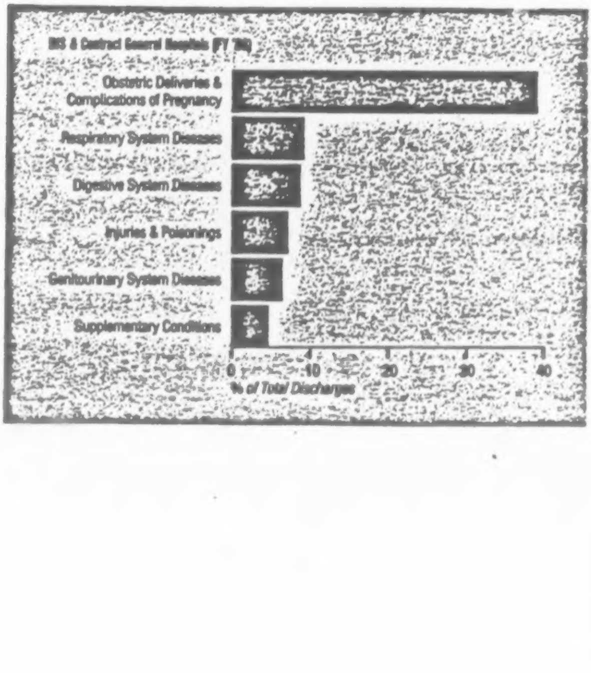

Table 5.8

Ten Leading Causes of Hospitalization by Sex FY 1988

Indian Health Service Direct and Contract General Hospitals

Male		
Diagnostic Category	Number of Discharges	Percent of Total
All Categories	33,732	100.0
Injuries & poisonings	6,053	17.9
Respiratory system diseases	5,483	16.3
Digestive system diseases	4,042	12.0
Circulatory system diseases	2,475	7.3
Mental disorders	2,296	6.8
Symptoms & ill-defined conditions	2,274	6.7
Supplementary conditions	1,587	4.7
Nervous system and sense organs	1,519	4.5
Skin & subcutaneous tissue diseases	1,491	4.4
Endocrine, nutritional & metabolic diseases	1,403	4.2
All other	5,100	15.1

Female		
Diagnostic Category	Number of Discharges	Percent of Total
All Categories	57,827	100.0
Obstetric deliveries and complications of pregnancy & puerperium	22,422	38.9
Respiratory system diseases	5,078	8.8
Digestive system diseases	4,728	8.2
Injuries & poisonings	3,920	6.8
Genitourinary system diseases	3,545	6.2
Supplementary conditions	2,626	4.6
Symptoms & ill-defined conditions	2,621	4.5
Circulatory system diseases	2,379	4.1
Endocrine, nutritional & metabolic diseases	1,780	3.1
Mental disorders	1,544	2.7
All other	6,974	12.1

SOURCE: On-Request Reports 19 and 21.

Chart 5.10

Hospital Discharge Rates by Age

For both the Indian Health Service (FY 1988) and U.S. (CY 1987), discharge rates were highest for the age groups under 1 year and over 64 years. Beyond age 4, the U.S. rate was greater than the Indian rate except for the age group 20 through 24 years.

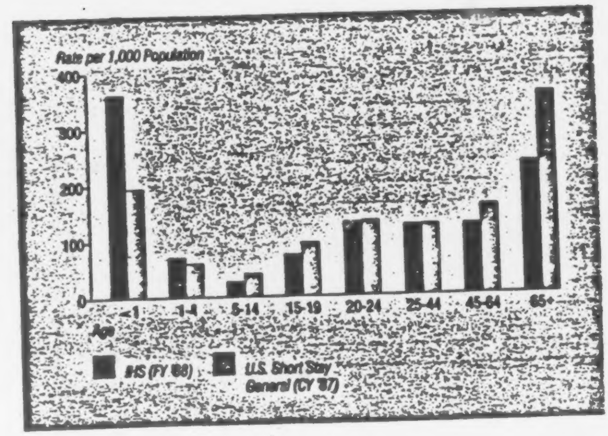

Chart 6.1

Alcoholism and Substance Abuse—Treatment Workload

An emphasis was established in FY 1986 on prevention activities. This has resulted in fewer inpatient days (22% decrease) and about the same number of outpatient visits between FY 1985 and FY 1988.

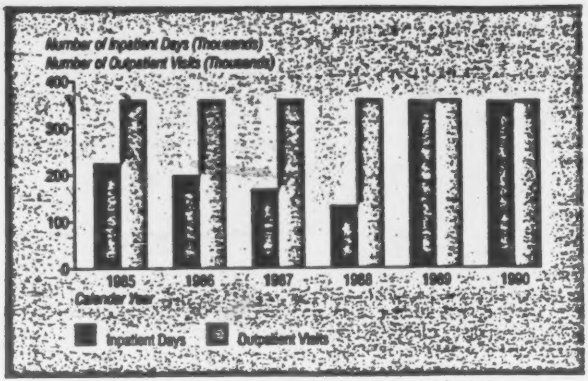

Table 6.1

Alcoholism and Substance Abuse Treatment Workload FY 1985-1988

	1985	1986	1987	1988
Inpatient Days	224,078	209,823	186,329	174,394
Outpatient Visits	361,036	358,542	363,960	369,837
Unduplicated Count of Clients Treated on an Inpatient and/or Outpatient Basis	20,793	19,653	19,811	21,251

NOTE: Excludes data for clients treated in Alaska who are reported through the use of the State managed reporting system. This workload does not overlap with workload from IHS and Tribal (direct and contract) inpatient and outpatient facilities.

SOURCE: Alcoholism Treatment and Guidance System (ATGS)

Chart 6.2

Alcoholism and Substance Abuse—Information and Prevention/Education Services

Between FY 1985 and FY 1988, information contacts increased 35% and prevention and education sessions increased 182%. These activity counts do not include treatments through outpatient visits.

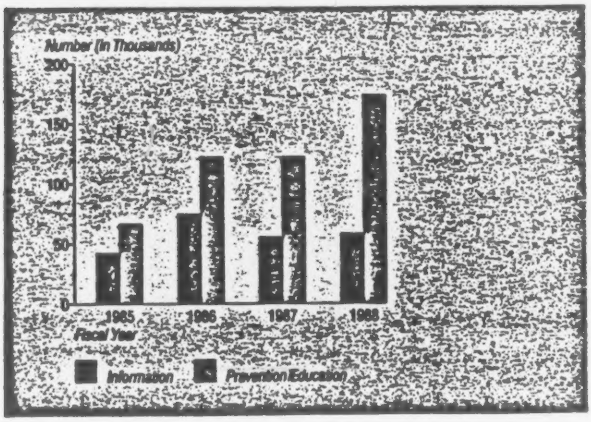

Table 6.2

Alcoholism and Substance Abuse Information and Prevention/Education Services Provided FY 1985-1988

Type of Service Provided	1985	1986	1987	1988
Information	43,014	75,394	54,772	58,156
Prevention/Education	66,130	122,237	121,774	173,045
Total	109,144	197,631	176,546	231,201

NOTE: Excludes data for clients treated in Alaska who are reported through the use of the State managed reporting system. This workload does not include treatment provided on an inpatient or outpatient basis.

SOURCE: Alcoholism Treatment and Guidance System (ATGS)

Chart 6.3

Alcoholism and Substance Abuse—New Treatment Cases

As a result of the emphasis on prevention activity, there has been an increasing trend in the number of youth in treatment. In FY 1985, youth represented 16% of all new cases while in FY 1988 they represented 20% of the new cases.

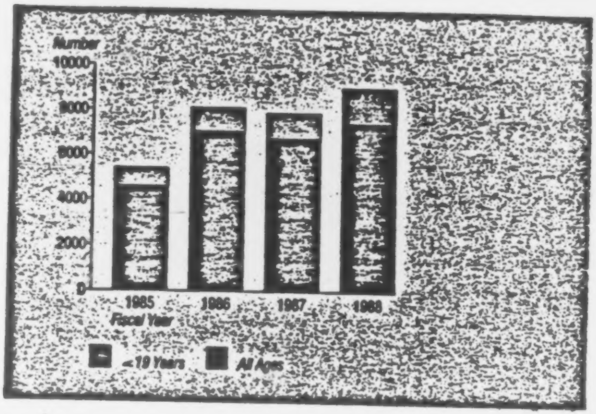

Table 6.3

Alcoholism and Substance Abuse New Treatment Cases (Youth and All Ages) FY 1985-1988

New Treatment Cases by Age	1985	1986	1987	1988
All Ages	4,539	7,000	6,656	7,369
Under 19 Years	729	975	1,036	1,457
Percent of All New Cases Under 19 Years of Age	16.1	13.9	15.6	19.8

NOTE: Excludes data for clients treated in Alaska who are reported through the use of the State managed reporting system. This workload does not overlap with workload from IHS and Tribal (direct and contract) inpatient and outpatient facilities.

SOURCE: Alcoholism Treatment and Guidance System (ATGS)

Chart 6.4

Alcoholism and Substance Abuse—New Clients as a Percent of All Clients

Since FY 1985, there has been an increasing trend in outreach work. In FY 1985, new cases were 22% of the total cases. In FY 1988, this percentage increased to 38.

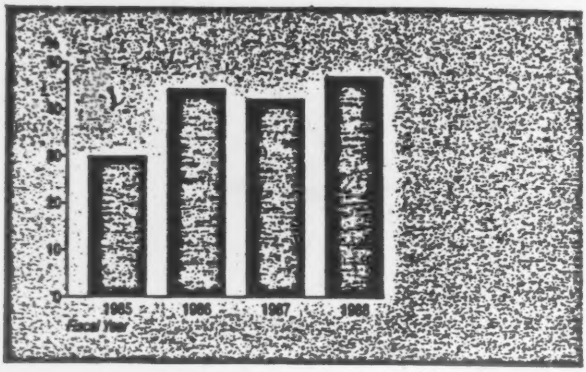

Table 6.4

Alcoholism and Substance Abuse New Clients as a Percent of All Clients Treated FY 1985-1988

	1985	1986	1987	1988
Unduplicated Count of Clients Treated on An Inpatient and/or Outpatient Basis	20,793	19,653	19,811	19,480
New Clients Treated	4,539	7,000	6,656	7,360
Percent of Clients Treated That Were New Clients	21.8	35.6	33.6	37.8

NOTE: Excludes data for clients treated in Alaska who are reported through the use of the State managed reporting system. This workload does not overlap with workload from IHS and Tribal (direct and contract) inpatient and outpatient facilities.

SOURCE: Alcoholism Treatment and Guidance System (ATGS)

TESTIMONY OF DENISE DOUGHERTY, PH.D.
U. S. CONGRESS OFFICE OF TECHNOLOGY ASSESSMENT

BEFORE THE
U. S. SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

MENTAL HEALTH ISSUES

September 14, 1989

Senator McCain, I am pleased to appear before you to present testimony to the Committee.

As you know, OTA has provided information to the Committee previously on both the general health and the mental health of Indians, and on the strengths and weaknesses of current health services for Indians (U. S. Congress, OTA, 1986b, 1988, 1989). Currently, OTA is at work on an assessment of adolescent health issues.[1] The Chairman of the Senate Select Committee on Indian Affairs was one of the primary requesters of the adolescent health assessment and interest was expressed by the Chairman and other requesters that OTA's adolescent health assessment pay particular attention to the needs of Indian adolescents. In addition, the Chairman of this Committee asked OTA to prepare a special report on services addressing the mental and emotional health needs of Indian adolescents. This special report is in the final stages of preparation, but has not yet been released by OTA.[2] However, today OTA can provide some general observations about mental health services for Indian adolescents based on that report. Many of these observations are applicable to the mental health services available to Indians of all ages, not just adolescents, and may be helpful as the Committee considers S. 1270.[3]

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1 The full assessment will be released in 1990.

2 Release is expected in October 1989. OTA would like to acknowledge the assistance of Spero Manson, Lois Bergeisen, and a panel of experts, including representatives of IHS, BIA, NIMH, and Indian tribes, in the preparation of the special report on the mental health of Indian adolescents.

3 S. 1270 is a bill introduced by Senators McCain, Murkowski, and DeConcini, that would provide for an Indian mental health demonstration grant program.

Need for Mental Health Services for Indians

OTA's detailed examination of Indian health status information published in 1986 revealed substantial discrepancies between the health status of Indians living in Indian Health Service service areas and the United States population taken as a whole (U. S. Congress, OTA, 1986b, 1988, 1989). Perhaps most striking, in the 3-year period centered in 1981, 37 percent of Indian deaths occurred in Indians younger than age 45, compared with only 12 percent of U. S. all races deaths occurring in that age group. The reasons for these deaths are primarily "social" or external causes of deaths, including accidents, suicide, homicide, and alcohol abuse. Even the predominant physical causes of death among younger Indians, such as various causes of infant mortality, heart disease and diabetes, may be explained in part by behaviors. Taken together with the social conditions in which most Indians live (U. S. Congress, OTA, 1986b), these data suggest that Indians could benefit from mental health care.

More recent data we have been synthesizing on the mental health needs of Indian adolescents suggest that this group in particular needs mental health services. Compared to students in Minnesota, for example, Indian students are twice as likely to report being sad, discouraged, and hopeless, to feel that life is uninteresting, and to feel emotionally insecure (University of Minnesota, 1987; University of Minnesota, preliminary unpublished data).[4] One out of five Indian adolescents report being depressed (University of Minnesota, preliminary unpublished data).

Given their fragile and stressed emotional health, it is not surprising that one out of five Indian females, and one out of ten Indian males, report having ever attempted suicide,

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4 These data are somewhat limited in that they reflect the responses of only 2,700 Indians in three service areas. Further, the data consist of self-reports and, data collection was limited to students enrolled in school, and the information may not reflect the problems of Indian adolescents who have dropped out of school. However, the research design is strong in that comparable data were collected, using almost the same survey instrument, from a wide spectrum of adolescents in the State of Minnesota; the items were drawn from previous research. Questionnaire design and data collection for this study were funded by a joint IHS-USDHHS Office of Maternal and Child Health grant to the University of Minnesota. Data have been collected, but not completely analyzed, from an additional 15,000 Indian students. Additional data analysis is being conducted by the IHS, and used to help tribes develop health promotion and disease prevention activities.

most within a year of the survey date (University of Minnesota, preliminary unpublished data). A review of recent mortality data[5] suggests that the mortality rate from suicide is rising among 10- to 14-year-old Indians in IHS service areas, and in 1986 was 4.6 times that of the U. S. all races population.[6] The suicide death rate for 15- to 19-year-old Indians was 2.6 times that of the U. S. all races population of that age in 1986.[7]

Living conditions for Indian young people help to explain their internal feelings. Indians are likely to live in poverty; some live in extreme isolation (U. S. Congress, OTA, 1986b). Forty percent of Indian students surveyed by the University of Minnesota live in single parent households; this compares to 17 percent of Minnesota students living in such households. Twelve percent of Indian students reported that one or both of their parents were dead, compared to approximately 4 percent of Minnesota students. One out of four students reported that their parents had a drinking problem (University of Minnesota, preliminary unpublished data).

Eighteen percent of Indian females surveyed reported being physically abused, and 14 percent reported being sexually abused; comparable figures for male Indian students were 7.2 percent and 2.3 percent. Indian students were up to 6 times as likely to report being worried about possible physical or sexual abuse than Minnesota students (University of Minnesota, preliminary unpublished data).

OTA's review of the literature on mental health needs of adolescents[8] suggest that these types of problems are longstanding in Indian communities, and were true to some degree among Indian adolescents of 20, even 50, years ago.

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[5] Based on information made available by the Indian Health Service.

[6] In 1986, the suicide death rate for Indians 10- to 14-years old was 6.9 per 100,000 population; the comparable figure for 10- to 14-year-olds in the U. S. was 1.5 per 100,000 population. Caution should be used in interpreting these figures because of the small population base among Indians, and difficulties in making age-specific estimates of the IHS service area population between census years.

[7] Calculated from suicide death rates of 26.3 per 100,000 population among Indian 15- to 19-year-olds and 10.2 per 100,000 population among U. S. all races 15- to 19-year-olds.

[8] This review will be part of OTA's forthcoming special report on the mental health of Indian adolescents.

Mental Health Services for Indians

Mental health services for Indians of all ages are extremely limited. Of the entire IHS budget in fiscal year 1989, only $13.1 million, or 1.3 percent, was allocated specifically for mental health services for a per capita allocation of $11.89 per Indian person per year (USDHHS, PHS, IHS, 1989).[9,10] As of April 1989, IHS supported only 236 direct care mental health providers (USDHHS, PHS, IHS, 1989).[11]

What these limited resources mean is that the most common program model is a crisis-oriented outpatient service which is staffed by one or more mental health professionals, often with the assistance of a local tribal mental health technician (USDHHS, PHS, IHS, 1989b). Specialized mental health services for populations such as children and the elderly usually are minimal because of limited resources and difficulties in recruitment of trained specialists. While approximately 43 percent of the service population are children and adolescents 19 and younger[12] (USDHHS, PHS, IHS, OPEL, Division of Program Statistics, 1989), only 5 percent (12) of IHS's direct care providers have been professionally trained to work with children or adolescents (USDHHS, PHS, IHS, 1989).[13]

The basic problem of resources sets the overall foundation for understanding that mental health services for Indians, including Indian adolescents, are inadequate. OTA's review

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[9] Comparable figures for the nation as a whole are extremely difficult to derive, primarily because the number of people in private therapy is not known. In 1985, State governments *alone* spent an average of $43 per capita on adult mental health treatment (National Association of State Mental Health Program Directors, 1987). Few States were able to disaggregate expenditures for children from those for other age groups; those that were estimated spending $9 per capita for services specifically for children. These figures are not comparable to that for the IHS, primarily because State Governments spend about 75 percent of their mental health treatment dollars on inpatient care (NASMHPD, 1987). The IHS has only two inpatient psychiatric units, with a total of 25 beds (USDHHS, PHS, IHS, 1989).

[10] These resources are distributed somewhat equally across IHS service units; approximately 80 percent of the 127 service units have implemented a formal mental health service program (USDHHS, PHS, IHS, 1989).

[11] One hundred ninety of these positions are IHS employees; 46 work in tribally controlled "638" mental health programs.

[12] Twenty-three and three-tenths percent are adolescents aged 10- to 19, and 21.3 percent are children aged birth to 10.

[13] The overall ratio of mental health providers to Indians in the IHS service population (an estimated 923,407 people as of fiscal year 1988) is 2.5 to 10,000 population.

of mental health services for adolescents found additional issues that need to be addressed if mental health care is to be improved (U. S. Congress, OTA, in preparation). These include the need for information about the nature and extent of mental health problems among Indian adolescents; the need to make services consonant with the cultural, spiritual, and religious values of Indians; the need for community participation in the design and delivery of mental health services, including the participation of adolescents; the need for coordination with other IHS programs and with other local, State, and Federal agencies; and the need for information about the effectiveness of mental health services for Indian adolescents. These needs overlap in that a number of questions would be amenable to research. There is great debate, for example, about the relative effectiveness of Western-style vs. traditional mental health services for Indians. Because Indian adolescents in particular face choices about the extent to which they wish to remain on the reservation, the issue of incorporating traditional values into mental health services, or basing mental health services on traditional concepts, would seem an especially important one to address. Adolescents are in particular need of coordinated services, because they may not have the expertise to know that they should seek care from a mental health professional, or they may fear the stigma attached to doing so. Thus, school professionals, pediatricians and other primary health care providers, criminal justice personnel, tribal leaders, and other community members should be alert to the needs of adolescents that can result in mental health problems.

Although a great deal is known about how to treat the mental health problems of children and adolescents in general, a great deal remains to be learned (Institute of Medicine, 1989; U. S. Congress, OTA, 1986a). OTA and, more recently, the Institute of Medicine found this to be true of mental health care for all populations, but it seems especially pertinent to Indians. OTA was unable to find any scientifically rigorous research on the best way to approach Indian adolescents with mental health problems, thus making the task of preparing a report with options for Congress to consider quite difficult. This is not to say that current approaches to Indian mental health services are wrong. OTA found a number of promising approaches to improving the mental health of adolescents, that are deserving of more thorough evaluation.

The Laguna-Acoma Teen Center in rural New Mexico, for example, incorporates a number of features that experience suggests would help to improve the mental health of adolescents.[14] Information about the effectiveness of the Teen Center is currently being inferred from utilization data and surveys and interviews with adults and adolescents in the community; a summative evaluation related to outcomes is planned for the future (Davis, Hunt, and Kitzes, 1989). The Indian Health Service Mental Health Programs Branch recently formed a special initiatives team that goes out to Indian communities with reason to believe they face an imminent youth suicide problem (LeBruyn, Humbaugh, and Valdez, 1988). IHS has also been implementing a quality assurance program in its mental health programs branch (USDHHS, PHS, IHS, 1989); data collected from quality assurance activities could be rigorously analyzed and compared with mental health outcomes data. In addition, traditional approaches, such as sweat lodges, to helping Indian adolescents with their mental and emotional needs continue to be used, and could be evaluated. Throughout the nation and abroad, consumers are becoming increasing involved in planning mental health services (Barker and Peck, 1988), and providers of services for young people are beginning to seek their continuing assistance.[15] These participatory approaches are consonant with the explicit goal of Indian self-determination and tribal control of health services (Public Law 98-638 and Public Law 100-472) as well as findings from social psychological research, but their appropriateness to mental health services and their effectiveness in improving the mental health of participants has not been evaluated.

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[14] The Teen Center was developed with community participation; is administered by the University of New Mexico, and funded by the IHS. Most notably, teenagers themselves were involved in the planning and design of the Center, and continue to serve as an ongoing Teen Advisory Group, consulting with the adult program directors, and preparing a peer-targeted, tenn-health-oriented newsletter, producing videotapes and skits, teaching fellow students and elementary school children, and other peer-oriented activities.

[15] For example, a teen health clinic in a Kaiser Permanente HMO in the Los Angeles area has a teen advisory committee. The Watts Health Foundation uses adolescent advisers.

When objective information is lacking, resources are scarce, and ideologies differ, individuals and agencies tend to compete with each other. These conditions apply to both the child and adolescent mental health field and to the Indian health field. Setting aside funds for evaluations of innovative services could be extremely important to improving the health and well-being of young Indians now and in the future, by providing an objective research base on which to build services. With specific reference to S. 1270, it may be important to ensure that funds are distributed equitably to promising projects for a variety of Indians of all ages, and with adequate assurances that rigorous evaluations will be done.

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PREPARED STATEMENT OF LLOYD IRVINE, COUNCIL MEMBER, CONFEDERATED SALISH AND KOOTENAI TRIBE

Mr. Chairman, Mr. Vice-Chairman and Distinguished Members of the Indian Affairs Committee:

We are pleased to present testimony on S.1270, legislation to establish an Indian Mental Health Demonstration Grant Program, to be administered by the Indian Health Service.

We want to begin by expressing our sincere thanks to Senator McCain for realizing the need for increased attention to the health care needs of the Indian people and for proposing this significant first step that could lead to a restructuring of the existing program. We concur in the Vice-Chairman's opinion that the existing IHS mental health is severely underfunded and that the extent to which it is not a priority at IHS is demonstrated by the fact that only three percent of the IHS budget is dedicated to mental health, (although this severe underfunding is certainly not limited to mental health).

We also agree and are elated with the recognition that Indian communities should be allowed to design a mental health program that will best serve the mental health needs of their population including the combining of existing clinical approaches with traditional cultural approaches. If we didn't know better we would have thought that Senator McCain was familiar with the mental health program on the Flathead Reservation when this bill was conceptualized because it follows our program's philosophy. It is for this reason that we asked to be allowed to testify to tell you about the exciting and positive things we are doing on Flathead in this area.

On the Flathead Reservation we have contracted the mental health services program and are the only tribe in the IHS Billings Area to do so. Our approach is somewhat unique and has led to our Mental Health/Social Programs receiving a "Group Citation Award" from the Director of Indian Health Service on November 7, 1988.

We won this award because we use a multi-disciplinary team approach. When we staff a case we get a referral and a mental health worker first does an intake. We take that information to a staffing team that consists of representatives from our juvenile probation program, tribal court social workers, our alcohol program, our narcotics addiction program, the Service Unit Director from the Indian Health Services, a Registered Nurse, and a psychiatrist. Therefore when we staff a case, because of the information that each one of those team members brings to the staffing we end up with good information about that patient, background information and frequently even a good history about that patients family.

What may be most unique about our Mental Health Program is it three components including its strong emphasis on traditional cultural care. These components are:

1) A strong clinical component which includes more standard forms of non-Indian mental health care including psychiatrists, clinical psychologists and para-professionals using existing clinical approaches for the provision of psychological care.

2) A very strong program involving the cultural aspects of our tribe utilizing our tribal elders including meetings in our longhouses on a weekly basis. Our cultural specialist gives specific cultural recommendations or refers that person out to be seen by other cultural specialists of our tribe.

3) We have a very strong community emphasis and involvement working with other community programs including groups such as the Adult Survivors, the Community Health Representative (CHR) program, the Alcoholism program and others.

Under a more standard mental health program there would only be a social worker and a psychologist or a psychiatrist and it is not really multi-disciplinary. Our tribe allows us to access all tribal programs into our staffing and that is what makes it unique. We have great cooperation with the different programs.

We like S. 1270 in that it seems to acknowledge the benefits that can come from traditional beliefs and traditional practices and encourages utilizing those practices into standard mental health practices. We believe very strongly in this approach. We have worked toward trying to perfect this practice for many years and feel we are getting better each year. We have spent a lot of time with cultural leaders and those who are considered experts in our traditional ways.

In the earlier days of our program through many intakes and analyses of patients we began to see one common denominator and that was a grieving process that our people were going through because of a loss of culture. Whether our patients had problems with drug abuse, sex abuse, depression, suicidal tendencies or other disorders, a core issue seemed to be this grieving. This loss of culture manifests itself in a loss of self identity and a loss of a good self image. These people frequently have a big void in their lives. Once this became evident to us we realized that we had to find people in our community who had the knowledge of our culture who could work with and teach these patients. These cultural representatives have helped provide a rebirthing of those who were grieving and ultimately an improved self-image.

It is important that this Committee realize that the present emphasis of our program was one that came out of experience. We did not just happen to be sitting around one day and say hey, let's add a cultural component to our program.' For the first three to four years we had a very standard mental health practice where patients would come to our offices and discuss their problems with a psychologist for an hour if they came at all. More frequently we would see people in jails after they had been violent or after they had abused a loved one or themselves. Now we believe we are getting into more preventative practices by seeing people before a crisis develops. But we have also been careful to incorporate modern day clinical practices and have worked very hard at designing a program and a methodology that we felt would benefit our people.

One way in which are seeing success with this program is through a considerable reduction in attempted suicides on our reservation which are down dramatically from where they were ten years ago. We still have much to do in this area but we are spending less time in the emergency rooms at hospitals than we used to. Because of the community based nature of our program and the acceptance it has in our community people seem more willing to deal with their mental problems before they reach the boiling over point.

You can therefore understand why we are supportive of the legislation and particularly are encouraged by Section 1 (d)(7) of the bill.

In spite of the praise and accolades of the IHS Headquarters, we are continually in a quagmire with funding differences with the Billings Area Indian Health Service over our approach. Our funding continues to be insufficient as a tribally contracted program particularly when viewed in comparison to IHS direct care programs and particularly when viewed in light of the fact that we are one of the largest tribes in the Billings Area. It would appear that we are being punished for 638 contracting this program. The following is provided for your observation on this point:

Mental Health - Billings Area (in thousands)

IHS Direct Operation		Tribal 638 Operating	
Blackfeet	192.3	Flathead	63.9
Crow	166.5		
Fort Belknap	113.6		
Fort Peck	189.3		
N. Cheyenne	93.0		
Rocky Boy	67.4		
Wind River	122.0		
Area Office	142.4		

While we are generally quite supportive of this legislation, there are provisions that cause us some concern. We are skeptical about the benefits that will accrue from Section 1 (b)(2) which mandates that fifty percent (50%) of the proposed funding go to Inter-tribal consortia. We assume the intent is to use these

Inter-tribal consortia to disseminate information and use the limited funding to help the greatest number of tribes possible. This approach might work in those States and regions where the consortia have had on-going programmatic activities but even there it would seem that to judge the success of the demonstration grant, you will need to have an on-reservation day-to-day hands on approach and that is not a role played by any consortia we are familiar with. Additionally, we are not aware of any programmatically active and strong Inter Tribal Councils in the Billings, Portland, or Aberdeen Areas. This omission may leave out the entire Upper Great Plains, Plains-Mountains and Pacific Northwest Tribes; regions where there are serious problem in the mental health area.

We believe that the funding should be made available on a need/competitive basis for every Tribe which chooses to make improvements to their mental health programs. We further believe that those Tribes who have contracted mental health services from the IHS via 93-638, and now operate those programs are in a much better position to infuse the additional resources into a more comprehensive, and culturally relevant program.

We would recommend that the committee consider amending the bill so as to provide on an area by area basis for the distribution of any additional financial resources. And as a part of that distribution that criteria be established which provides incentives, and locally acceptable programs for the treatment of mental health conditions.

We caution the Committee in that OMB will likely be looking for a reason to oppose the bill and one of their favorite arguments is that a proposed program duplicates existing services. Be careful in structuring this bill not to play into their hands. We concur with Senator McCain that there is are concrete connections between Indian mental health and drug and alcohol abuse but there are also previously authorized Indian drug and alcohol programs that (allegedly) exist so the Committee should be careful in creating duplicative criteria in this regard. Only when all other forms of payment have been exhausted, do we believe that dollars appropriated under S.1270 should be spent on direct treatment. This could be evaluated and considered in the Tribes submission to the area for funds and then judged against established criteria for competitive funds for demonstration projects. If indeed, the proposed intent of the legislation is aimed at restructuring the system then we believe that dollars under this act should be given priority for development as well as demonstration.

Since the amendments to P.L. 93-638, and its attendant regulations have been passed, we see little reason not to follow the appropriate revised grant reporting regulations and requirement, rather than adopting in the proposed bill itself a new set of reporting requirements. Perhaps, the committee should consider the revised 638 regulations for adoption and be included in their entirety in this bill.

We are concerned with the establishment of a new technical assistance office on mental health in the office of Research and Development in IHS. We question where the FTE and funding for the staff of this new office will come from. If past history repeats itself, this action, we believe, could lead to another bureaucratic bottleneck, and result in a drain of funds badly needed at the reservation level. One also has to question how the establishment of this new office would effect/inter-relate with the existing IHS organization structure at all levels of operation. It must be clear that the funds for the technical assistance office and the funds for this bill in general do not come from existing programs.

While we do perceive some benefits coming from the technical assistance office, such as information dissemination, the proposed legislation actually is drafted so as to provide to the Tribes the responsibility of developing a local process and we hope this technical assistance office does not become heavy handed in this regard.

We are also somewhat concerned about the 25% matching criteria. We assume the intent of the bill's authors was to weed out the tribes that are really interested in this as a demonstration program from those that only want more IHS money but we do have concerns about setting precedents. As this Committee has pointed out in the past, the United States has some legal responsibilities to provide health care to Indians and we want to make sure that in the future the U.S. does not say that they will only provide 75% of the health care costs and then only if tribes provide the other 25%. If this section is retained, there should be clear report language pointing ~~out~~ that this is not precedential and is only being allowed because this is a demonstration project.

We wish to thank the Committee for their continued effort and support to improve the lives of Native Americans in their endless struggle for survival and eventual parity.

TESTIMONY OF

THOMAS R. WHITE
GOVERNOR
GILA RIVER INDIAN COMMUNITY

BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
WASHINGTON, D.C.

SEPTEMBER 14, 1989

REGARDING S. 1270 TO PROVIDE AN INDIAN
MENTAL HEALTH DEMONSTRATION GRANT PROGRAM

Mr. Chairman, Senators, staff members, and representatives of all the Tribal groups in attendance, I am honored to appear before this Committee to express the views of the Pimas and Maricopas of the Gila River Indian Community regarding S. 1270, a bill to establish an Indian health demonstration grant program. We support enactment of S. 1270.

The Gila River Indian Reservation is located in South-Central Arizona and our northern boundary is immediately adjacent to the City of Phoenix and the Greater Metropolitan Phoenix area. Our Reservation is comprised of approximately 373,000 acres and the Community has a membership of over 13,000 members. More than 9,000 members live on the Reservation.

I. THE MENTAL HEALTH SERVICES PROVIDED INDIANS IN ARIZONA IS INADEQUATE.

Indians who live on Reservations, economically, are the poorest of all Indians and have extremely limited opportunities for employment. In addition, Reservation Indians have limited access to basic health services and have less access to professional mental health care. But the situation in the health field is improving. For instance, at Gila River, the new Hu Hu Kam Memorial Hospital opened in August, 1988, and provides comprehensive health services for Pimas, Maricopas, Tohono O'odham, and other Indians residing on or near the Reservation.

The Community views enactment of S. 1270 as a significant but preliminary step taken by the federal government to begin to deal with the adequacy and quality of mental health care provided to Indians. In the absence of substantial new appropriations for Indian mental health services, it is worthwhile to focus on demonstration projects in an effort to stimulate the development of innovative and culturally sensitive mental health techniques and programs.

Gila River has attempted to provide professional mental health services to Pimas and Maricopas. Our initial step in 1980 was to contract, through the P.L. 93-638 process, the behavioral health function of the Indian Health Service and we have steadily expanded this program. However, we still are unable to offer a full range of needed mental health services to eligible Indians.

During the eleven month period ending August 31, 1989, our Behavioral Health Program scheduled 3,179 visits and it is interesting to note that over fifty percent of the visits concerned minors. The types of diagnoses varied substantially and included major depression, bipolar depression, dysthymic disorder, attention deficit disorder, attention deficit disorder with hyperactivity, schizophrenia, parent/child problems, marital problems, ETOH abuse, conduct disorder, schizo affective disorder, enuresis, and sexual abuse.

The case load of our Program will increase because the increased awareness of mental health disorders and because of the availability of professional assistance. This means that the Community must plan for and be able to provide and expanded ranged of mental health services.

At this time our Program employs a psychiatrist, a psychologist, a master's level social worker, a case manager for the chronically mentally ill, a mental health technician, and administrative/secretarial personnel.

The goals contained in S. 1270 are important and if enacted into law will go a long way toward developing a firm foundation for the development of a comprehensive mental health program for Indians. Congress, IHS, and the states must recognize that the delivery of mental health services to Indians on Indian Reservations is vital to good health and must improve.

We agree that "innovative and community based" services must be developed. But it should be kept in mind that many Indians simply do not have access to professional mental health care. We strongly urge that the IHS and Congress make a commitment to long term funding of Indian mental health care. One apparent problem with S. 1270 is the limited number of demonstration grants available in any fiscal year. The needs in Arizona alone could justify awarding the ten grants available to Arizona Tribes.

The three year limitation is an impediment to long range planning and stability in reservation based mental health care programs. For instance, if a program is developed which meets the goals and objectives established by S. 1270, the program should be funded for a longer term. Like other health care areas, mental health services must be provided on a stable, continual, and consistent basis to be effective.

II. THE STATE OF ARIZONA DOES NOT PROVIDE MENTAL HEALTH CARE TO INDIANS WHO NEED TO BE INVOLUNTARILY PLACED IN THE ARIZONA STATE HOSPITAL.

A major component of any mental health care system is the capability of involuntarily placing patients in a locked and secure mental health care facility when the patient is a danger to himself or others. No such secure and locked facility is available to Arizona Indians who require these special services and who reside on an Indian Reservation. The basis for the State of Arizona refusing such mental health care to Reservation Indians is the decision in White v. Califano, 581 F. 2d 697 (1978) upholding a decision of the United States District Court, South Dakota. White v. Califano, 437 F.Supp. 543 (1977). Arizona refuses to recognize Tribal court orders placing mentally ill Indians in the State Hospital or admit that Indians are citizens of the State of Arizona and therefore entitled to mental health services like all other state citizens.

Indians who reside on Indian Reservations are citizens of the State of Arizona and are entitled to State services. Tribal land within the boundaries of a state have always been considered to be geographically a part of the state it is located in. Langford v. Monteith, 102 U.S. 145 (1880); Worchester v. Georgia, 31 U.S. (Pet.) 515, 560-61 (1832). Indian Reservation residents must be considered to be residents and citizens of the state they live in and therefore entitled to all benefits provided all state citizens. Equal access to specialized mental health services offered at the Arizona State Hospital (ASH) is one of the benefits that a citizen who lives on an Indian Reservation in Arizona clearly is entitled to.

The Supreme Court of Arizona held in Harrison v. Laveen, 67 Ariz. 337, 196 P.2d 456, (1948), that Indians residing on Indian Reservations are residents of the State of Arizona and eligible to vote in state elections. The court, in arriving at the decision that Reservation Indians were state citizens, noted that Frank Harrison, a member of the Mohave-Apache Indian Tribe, had served in World War II and received an honorable discharge. The court stated:

> Tribal Indians held to be subject to the Selective Training and Service Act of 1940, U.S.C.A. Title 50, Appendix, § 301 et seq., in the case of Totus v. United States, D.C. 39 F.Supp. 7, and we know that from our own State thousands of these native Americans served in the armed forces with pride and distinction, e.g., Ira Hamilton Hayes, a Pima Indian, participated in the epochal raising of the stars and stripes on Mt. Surabachi on Iwo Jima. 67 Ariz, at 343.

Harrison v. Laveen is in line with other cases that hold that residence on a Reservation alone may not bar an Indian from state services. Acosta v. San Siego County, 126 Cal. App. 2d 455, 272 P.2d 92 (1954); Montoya v. Bolack, 70 N.M. 196, 372 P.2d 387 (1962); State v. Natonabah v. Board of Education, 355 F. Supp. 716, 720-25 (D.N.M. 1973).

It is the position of the Community that decisions of our Community Court and other Tribal Courts committing Indians to the Arizona State Hospital should be recognized and afforded full faith and credit. Arizona courts have not yet ruled on this specific issue.

Arizona courts have consistently recognized judgments of Indian Tribal courts and in effect afforded judgments of Indian courts full faith and credit. Begay v. Miller, 70 Ariz. 380, 222 P.2d 624 (1950). In Begay v. Miller the Arizona Supreme Court recognized a divorce decree of the Navajo Tribal Court which compelled the granting of a petition for a writ of habeas corpus freeing a Navajo Indian from a contempt of court citation of an Arizona Court. The Court stated:

> . . . we see no constitutional basis for the courts of Arizona refusing to recognized the validity of such decrees. Id. at 386.

The Arizona Supreme Court again recognized a judgment of the Navajo Tribal Court in Re. Lynch's Estate, 92 Ariz. 354, 377 P.2d 199 (1962). The Supreme Court determined that a will that had been admitted in probate proceedings of the Navajo Tribal Court also should be admitted in state court proceedings. The court stated:

> We are therefore of the opinion that the proceedings held in the Navajo Tribal court must be treated the same as proceedings in a court of another state or foreign country, and that A.R.S. § 14-343 is applicable to the case at bar. 92 Ariz. at 357.

While the principle of comity was not the express basis for recognition of the Navajo judgment, the effect was the same. The judgment was implicitly grounded on principles of comity. The bottom line was that the Navajo Court judgment was afforded full faith and credit.

The most recent discussion of recognition of the status of tribal court judgments is found in Brown v. Babbit Ford, Inc., 117 Ariz. 192 (Ct. App.), 571 P.2d 689 (1977). The Court of Appeals discussed the concept of "comity" and stated:

> In general, the principle of "Comity" is that the courts of one state or jurisdiction will give effect to the laws and judicial decisions of an other state or jurisdiction, not as a matter of obligation, but of deference and mutual respect. [Citations omitted] Id. 117 Ariz. at 198.

Principles of comity may apply between independent sovereign jurisdictions but there seemed little doubt in the opinion of the Court that the Navajo Nation was and is an independent sovereign. The Court of Appeals then proceeded to recognize legislative enactments of the Navajo Nation based on principles on comity. Id.

The decision in White v. Califano, 437 F.Supp. 543 (1977), aff'd. 581 F.2d 697 (8th Cir. 1978) did reject a Tribal court commitment order in South Dakota. However, there was little discussion whether tribal court orders may be recognized in South Dakota. The situation clearly is different in Arizona as is evident from the discussion above. Furthermore, in Necklace v. Tribal Court of the Three Affiliated Tribes of Fort Berthold Reservation, 554 F.2d 845 (1977) in considering a habeas corpus petition of an Indian confined in the North Dakota State Hospital, the court had no difficulty with the committing Tribal court order. The Indian was in custody pursuant to a tribal court order and therefore remained in the custody of the Tribal Court while undergoing treatment in the State Hospital.

The Community has made extensive efforts to inform and advise the Arizona Department of Health Services, the State Legislature, the State Hospital, the Attorney General's Office, of this problem. In fact, at a recent meeting attended by representatives by affected state agencies and the Legislature, the possibility of Tribes and the State entering into

Intergovernmental Agreements regarding placement in the State Hospital was seriously discussed. However, no decision has yet been made.

The final solution may lie with the Congress. Perhaps the only feasible way to resolve this crisis is to enact legislation much like the Indian Child Welfare Act.

III. CONCLUSION

The Community supports enactment of S. 1270. In addition, appropriations for Indian mental health services must be increased and services must be consistent with the cultural traditions of the affected Tribe. Finally, special attention must be devoted to the delivery of mental health services for those Indians who are in most need of these services, Indians who live on Reservations.

seattle indian health board

Testimony
at a hearing before
the Senate Select Committee on Indian Affairs
regarding

INDIAN MENTAL HEALTH ISSUES

Presented by

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September 14, 1989
Washington, D.C.

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Mr. Chairman,

The Seattle Indian Health Board (SIHB) is pleased to provide this testimony in support of S. 1270. The Seattle Indian Health Board was founded twenty years ago, with the single mission to improve the physical, mental, spiritual and social health of American Indians and Alaska Natives in the greater Seattle area through the provision of culturally sensitive services. In our efforts to impact on the health status of Indian populations, we have found that the underlying mental status of Indian people plays a major role in their overall health and well-being.

Background

The Seattle Indian Health Board (SIHB) began in 1970 as a volunteer medical clinic serving Indian people in the Seattle area who were otherwise ineligible for the Indian Health Service because they had left the reservation and for whom the existing urban health delivery system was unresponsive. The need for alcoholism treatment services became apparent; and in 1972 SIHb began providing these services as well. Many of the families seen by the SIHB were isolated from the community because of the dispersed pattern of Indian residences in the Seattle area. An "outreach" team was implemented to bring Indian people into the clinic for services or to go and visit families in their homes for follow-up and referral. These outreach workers frequently found themselves in situations where the Indian client relied on them to listen to the litany of problems they were having. In some cases these problems were social welfare complications that required advocacy with local agencies on behalf of the individual. But in many cases, individuals began to express their feelings of depression, hopelessness and thoughts of suicide. Given the range and complexity of psychosocial and related problems being seen by outreach workers and in SIHB clinics, the Seattle Indian Health Board recognized the need for trained mental health expertise. In 1976, a psychiatrist from the University of Washington began to volunteer his time to help Seattle Indian Health Board staff deal with the mental health issues of our patients. In 1977, a small grant from the local King County Mental Health Division allowed the Seattle Indian Health Board to begin limited mental health services to Indians in need of mental health therapy. Until this time, both the local Community Mental Health Centers and statewide agencies reported very few Indian clients seeking treatment. Reports further indicated those who did manage to access existing mental health agencies seldom returned after the first visit. (A draft study prepared by the SIHB's Clinical Psychologist is attached to this testimony.)

In 1977 the Seattle Indian Health Board (SIHB) received funding from the National Institute of Mental Health to conduct a five year training program for Indian mental health paraprofessionals. Indian people with an interest in counseling were recruited to attend a local community college, receive Indian specific seminars at SIHB and experience a practicum at local Indian service agencies, including the Seattle Indian Health Board. The program produced a cadre of newly trained Indian people in the field, and an Indian mental health text book which today is still in demand by researchers and mental health professionals. The training program set the means by which a logical balance could be set to provide both traditional mental health clinical therapy and traditional Native cultural and spiritual support.

Today, the Seattle Indian Health Board (SIHB) provides the majority of outpatient mental health services the State of Washington reports as provided to Indian people with State resources. Because of the restrictions on State dollars, the primary treatment model is a traditional Western mental health clinical approach. A special program of Culturally Relevant Enhanced Minority Services is provided for chronically and severely mentally ill Indian people. This program offers activities which are based on Indian cultural values and ceremonies. The clients have become involved in holding feasts, powwows, giveaways and other ceremonies in this community. State and county service priorities funding the "chronically disturbed" client also limit the SIHB's ability to treat the needs of Indian people who frequently do not fall into the State's "chronic" definition.

Waiting lists to get into treatment at the Seattle Indian Health Board's mental health department are totally unacceptable. The current waiting list is six months long. While setting up therapy and support groups for the people on our waiting lists has been one option examined to provide help to those patients awaiting a therapist, the State of Washington and King County systems which provide funding for the services do not consider such support groups as legitimate services under the contract.

Cultural Oppression and Cultural Depression

While aggression against Indian culture is well documented in American history books, far too little has been discussed concerning its multi-generational effects on the mental status of Indian people today. Jane Middelton-Moz, Native American psychologist in Washington state, has completed extensive research on "cultural depression" and found that there are two major areas effecting Native Americans today. The first is the effects of the stigma and depression caused by forced acculturation. She states "One Native woman I worked with in urban Seattle had previously been through five inpatient and three outpatient alcoholism programs. Evaluations I received indicated that she was 'resistant to treatment.' As well as being diagnosed as "alcoholic", she also carried the diagnosis of "antisocial personality disorder," "hystrionic personality disorder," and "battered woman syndrome." Her use of alcohol and drugs began when she entered a white school system off her reservation in the seventh grade. She stated that this was the first time she realized that she was "stupid." She talked about being teased constantly in school and felt bad about herself, which she had never felt before. Both of her parents were alcoholic, but she said that she had always been cared for by her aunts and grandparents when her parents were drinking. She felt her childhood had been happy. Her grandmother had taught her the strengths and values of native culture, but she had often felt confused because her parents had never reinforced those values and seemed to feel "shame" at being Indian. She left the reservation when she was 18 to get a job in the city. She said she liked being with people and always let people who didn't have a place to stay or the money for housing stay with her. She was often confused when they would steal from her to beat her up, but said that she couldn't say "no" when someone was homeless. She had tried to kill herself once when she was drunk and consequently entered treatment. The only Indian in the treatment program, she felt alone and didn't understand what was being taught. She said she felt stupid, as she had felt in school.

Another woman with a similar experience told me, "My grandmother taught me that the heart tells you what to do and you should always listen to your heart for its lessons. Then you learn in school that your head should tell you what to do. The mind tells you something - that the heart is not the way white people tell you to be. It's really confusing."

Throughout treatment, neither of these women had been asked about the values they had learned in their culture, the strengths they felt concerning those values, or their confusion; neither had been asked about their grief concerning early education experiences or of the grief they felt in their parents; neither had been asked about their kinships network, the experiences of reservation life; and neither, even though one woman lived with her family on the reservation, had been asked to take part in family treatment.

Treatment programs designed in separation from the culture often ignore the grief and depression resulting from acculturation, the effects of stigma on the culture, as well as ignoring one of the most powerful tools in the healing process, the strength of the values of Native American and Alaskan people. Often not considered as well, is the powerful impact of peer pressure on the native person. Programs which remove the individual from his/her kinship network are destined to make statistics a self-fulfilling prophecy.

The effects of cultural oppression are multi-generational. We cannot presume that the entirety of the physical, emotional and spiritual trauma experienced by our grandparents have gone to the grave with them. On the contrary, a legacy of unresolved grief exists with us today.

Indian people who have grown up in communities with cultural depression receive mixed and often contradictory messages about their Indian-ness:

- Be proud of your heritage.
- Leave this reservation if you want to become somebody.
- Get a good education and come back and help your people.
- We can't hire an Indian person to run our program; we need a white person to do the job right.
- I could never work for my own tribe; they're too crazy.
- Shame on you for not knowing your own language.
- We don't talk about our beliefs in public. You shouldn't ask.
- He's just a heathen.

Cultural depression follows cultural oppression for the next generation and the next until the cycle is broken. Cultural depression is anger turned inward, hatred turned toward ourselves, toward our own people, toward our own identity as Indians. From 1986 to 1988, the Seattle Indian Health Board operated a national demonstration program funded by the Office of Minority Health to break the cycle of addictions among Indians in Seattle and with the ten Puget Sound tribes. It was discovered that in addition to the family dysfunctions caused by alcoholism and its abuse, participants in our project also described cultural depression as a major factor in their childhood and one which needed resolution.

Anna Latimer, M.A., director of this demonstration project, describes the significance of cultural depression and Indian mental health as follows: In our program, we have found that the effects of cultural oppression are equal to, if not more than the devastating effects of multi-generational alcoholism among Native Americans. Among the ten tribes and three urban agencies, cultural oppression has shown itself in the form of shame. "Shame is the inner experience of being looked down upon by the social group. It is the self judging the self. A moment of shame may be humiliation so painful or an indignity so profound that one feels one has been robbed of his or her dignity or exposed as basically inadequate, bad or worthy of rejection. A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, defective, unworthy, or not fully valid as a human being. (Facing Shame, page 5, Fossum and Mason. 1986).

We found that this pervasive sense of shame impacts an individual on many levels. Comments such as, "I've never felt worthy", "I can't deal with positive attention from the group", "I was afraid you would find out how inadequate I am", "I tried to kill myself because everybody thinks I'm just not worth anything" continue to be shared in support groups.

The pain runs very deep for many of us. It is rooted in abuse, personal violations, seductions and assaults where one's sense of self has been trampled, one's boundaries defiled. The absence of an affirmation of self is rampant among ourselves, our children and our communities. If we are unable to affirm ourselves as human beings, then a pervasive sense of cultural self-hate develops. It is this that we must bring to the forefront of our awareness and our hearts. In our program, we are just now identifying this phenomenon among ourselves. It is of utmost importance that clinical recognition of cultural self-hate as a family dynamic among Native Americans be addressed by mental health professionals and agencies. If not, we will continue the cycle of pain from the double-edged sword of alcoholism and cultural self-hate.

Alcoholism, Mental Health and Family Services

One of the most important challenges to developing a mental health demonstration model which is effective with Indian populations is to bridge the stormy gap between the mental health and alcoholism treatment communities. The split between the two disciplines has reached the Indian community and is perpetuated by funding agencies and professional associations. For the client, the family and the community struggling to recover from the pain brought about by multi-generational alcoholism and family dysfunction, the lack of coordination and support between the two professions is an inexcusable disservice.

The Seattle Indian Health Board (SIHB) operates the Thunderbird Treatment Center, the largest Indian operated alcoholism and drug treatment facility in the nation. Our counselors estimate that up to 95% of all female clients and 75% of all male clients who seek inpatient treatment at our facility, are the victims of child sexual abuse, and very likely from an alcoholic home. It has been the general position of alcoholism treatment models to not deal with these issues while in treatment for substance abuse. The reason cited is that it is felt the patient is not stable enough to deal with these childhood traumas. Perhaps another reason is the lack of expertise among substance abuse counselors to tackle these hard treatment issues. At least a year of sobriety is recommended prior to undertaking long term mental health therapy. Yet, there is not a system for such continuity of care. The likely scenario is that these unresolved mental health issues are not addressed, and later become sources for relapse. Additionally, Indian substance abuse counselors themselves are sometimes victims of unresolved childhood traumas and avoid these topics with clients.

The demonstration model previously mentioned adopted the position that multi-generational substance abuse has placed our population at severe risk for continued abuse. Utilizing a "Children of Alcoholics" model, the project trained natural helpers from Indian communities on the issues of growing up in alcoholic environments. What we found was that the vast majority, 90%, of the trainees were themselves adult children of alcoholics and that experiences and characteristics common among children of alcoholics, such as sexual abuse, physical abuse, neglect, chronic depression and low self esteem, were also common in these Indian communities. They represented the mainstream of their community and leaders in the helping field, and yet when seeking therapeutic support, none was available.

The majority of all Indian children today are still growing up in homes where one or both parents are actively involved in alcoholism or some other addiction. It is safe to assume that the cycle of alcohol, abuse, neglect and depression is continuing. Child sexual abuse is involved in 30-50% of all the Indian Child Welfare cases reported out of the Seattle Indian Unit of the State's Child Protection Services. Yet, there are no Indian-specific mental health counseling resources with the adequate capacity to meet the needs of these children and their families. Child abuse is drastically under-reported in Indian country, particularly child sexual abuse.

Dr. DeeAnn DeRoin, a physician at Haskell Indian College, presented her findings on Indian child abuse last year, and found that, while the rate of total reported cases of abuse for Indian children was less than the rate of report for the general public, the rate of actual convictions for Indian abuse cases far exceeded the rate of convictions for cases reported in the general public. This suggests that Indian child abuse is only being reported in those gross, undeniably apparent situations, and that suspected cases of abuse are largely going unreported.

The effects of alcoholism, violence and family dysfunction on the children place them at risk for social isolation, school drop-out, alcoholism, drug abuse, depression, low self esteem, promiscuity, self destructive behavior, suicide and a very high likelihood that, left untreated, they will repeat this cycle of dysfunctional behavior with their own children.

Although the Anti-Drug Amendments of 1988 provided specific language to the Secretary of HHS to review the findings and recommendations of the Children of Alcoholics demonstration project in Seattle, the Indian Health Service has not yet made such an inquiry in to the project.

There is currently no coordination at the state or federal levels between the child welfare, mental health, or substance abuse treatment systems. Families in crisis cannot be dealt with effectively as a total unit. Rather, the piece meal approach is necessitated by fragmented resources. A coordinated comprehensive holistic approach to Indian mental health care is needed if services are to be truly effective.

Urban Indian Populations

S. 1270 as it currently reads does not provide for funding demonstration projects in Urban areas. The needs in urban areas such as Seattle are as great as in many reservation communities.

Congress has recognized an obligation to provide limited health services to urban Indian populations through the enactment of the Indian Health Care Improvement Act of 1976. Under Title V of this legislation, Congress provides for outreach, referral and direct health services delivery to urban Indians. Special recognition for Urban Indian populations was based on the following:

- o US census found that over 50% of all Indian people in the US live off the reservation and most reside in Urban Areas.
- o The American Indian Policy Review Commission found that the Bureau of Indian Affairs relocated of 160,000 Indian people from reservation to urban areas in the ill-fated "Relocation Program." This program targeted some of the largest cities in the country and was the primary source creating urban Indian populations.
- o Indian people who were relocated to urban areas became ineligible to receive assistance from the IHS or BIA and became isolated in the cities, rarely availing themselves of local resources.
- o Urban Indian populations suffer the same level of ill health as reservation Indians in terms of life expectancy, deaths from alcoholism, suicide, accidents and other lifestyle influenced health problems.
- o Indian people migrate back and forth between urban and reservation communities and need a comprehensive service network.

Over 220 tribes are represented in the Seattle Indian Health Board's registered patient population. Unlike reservation settings, there are multiple tribal cultures and varying levels of cultural identity among urban Indian populations. Compounded by factors of discrimination, cultural isolation, lack of support systems, and other economic, social and psychological stresses encountered in the urban environment, treatment models for Indians living on reservations and those in urban areas may differ somewhat in order to achieve a successful treatment outcome for specific individuals. Urban program models may give less attention to community and tribal differences which might assume paramount importance in rural areas and on reservations.

Strengths and Weaknesses of the Current System

The Indian Health Service has been most effective when given the challenge to address health problems which are responsive to clinical intervention. IHS has been extremely successful in its attacks on such health problems as tuberculosis, maternal mortality and infant mortality, etc.

Today's major health problems require a different approach than the one with ~~which~~ the Indian Health Service feels most comfortable. Problems such as multi-generational substance abuse, family dysfunction, chronic depression, suicides, domestic violence, child abuse, etc., require innovative and coordinated efforts by IHS, communities and other providers in the Indian health and social system. Without specific legislative instruction, it is likely neither the Bureau of Indian Affairs nor the Indian Health Service will assume the necessary responsibility to create a coordinated, sustained community mental health initiative.

Resources in the Indian Health Service are too few to address the need for basic mental health therapy in the Indian community. IHS spends less than one percent of its resources in the area of mental health. The Bureau of Indian Affairs with its responsibility for "Child Welfare" has the potential yet lacks the training and staffing to address mental health needs of Indian children.

1. The Indian Health Service was founded on a "medical" model program and maintains this basic clinical structure in its operations.

2. The Indian Health Service has been extremely successful in its attack on such health problems as tuberculosis, maternal mortality, infant mortality and other problems which respond to clinical intervention.

3. The Indian Health Service has not been particularly effective nor creative in dealing with problems which exist outside clinical structure such as alcoholism, substance abuse, domestic violence, suicide, homicide, accidents, sexual abuse or mental problems.

4. The Bureau of Indian Affairs while representing a significant role in Indian communities has shown very little interest in mental health despite its responsibility to provide social services, law enforcement and child protection.

5. Territorial battles especially among the mental health and substance abuse employees who protect their professional disciplines will need to be addressed and overcome for an effective comprehensive community-based mental health initiative to be achieved in Indian country.

6. Indian mortality today is largely a result of lifestyle behavior and the exposure to those related risks. Indian wellness is dependent upon a comprehensive support system which can address personal, family, tribal and community-wide recovery and support for healthy behavior.

Recommendations

1. To amend the language of S. 1270 which will provide that at least 30% of the demonstration projects be targeted at urban Indian populations as defined under Title V of the Indian Health Care Improvement Act.

2. To require coordination between mental health and alcoholism treatment within the Indian Health Service system, and recognition of dual-diagnosis issues (mental health/substance abuse) within the Indian population.

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Ethnic Minority Mental Health in the late 80's: Problems and Proposed Solutions

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Running Head: Minority Mental Health

Abstract

Ethnic minorities have for centuries struggled to obtain adequate health and mental health care. In the last several decades, mental health providers, closely tied to ethnic minority communities, have examined the elements involved in the delivery of adequate services to minority clients. These assessment and treatment issues are briefly reviewed and discussed. The minority mentah health clinics of King County, Washington offer innovative and effective treatment approaches that were developed in close assosicaiton with the ethnic communities served. A close look however at need and utilization statistics indicate that King County service delivery remains inadequate. The situation would improve dramatically if minority mental health clinics, established by ethnic communities, were provided with adequate funds. These clinics would offer much better services if permitted to set their own service goals and priorities.

As long as good health care has existed, it has eluded ethnic minority communities. Studies in the 70's by Sue and colleagues (Sue 1976, Sue 1977, Sue & McKinney 1975, Sue, Mckinney Allen & Hall, 1974) demonstrated the appalling lack of adequate mental health services to ethnic minority clients in King County, Washington. As Sue published his work, the ethnic minority communities in King County created their own mental health clinics separate from those designed to serve distressed majority clients. In cooperation, these minority clinics continue to develop and expand services to the minority communities in and out of King County. These minority clinics have learned well the ways in which mainstream mental health must be altered to provide effective services. The minority mental health issues and concerns that face King County providers parallel those that have been articulated in the psychological literature.

Among those researchers most intimately connected to ethnic minority communities, there is general agreement on the nature of good ethnic minority mental health. Services must be tailored to the specific community served. The available quantity of these unique services must be adequate, and utilization must be service modifications.

Assessment

Rogler, Malgady, Constantino and Blumenthal (1987) note that services most likely to be effective are those that have been modified to fit the culture. Unfortunately, no commonly used assessment devices meet this criteria. Lopez and Nunez (1987), for example, reviewed the 11 most frequently used clinical and research assessment tools. The review included the *Diagnostic and Statistical Manual*, Third Edition (*DSM-III*); the Diagnostic Interview Schedule (DIS); the Schedule for Affective Disorders and Schizophrenia (SADS); the Structured Clinical Interview for *DSM-III*; the Structured Interview for *DSM III* Personality Disorders; and several other instruments. 8 of the 11 include at least one item related to culture. These items are used primarily to prevent the application of a diagnosis based on behaviors that are pathological in the majority culture but normal in the minority group. Two instruments assume a universal set of diagnoses can be applied across cultures. Westermeyer (1987), a proponent of the position that there are no culturally unique psychiatric disorders, contends that at least some *DSM-III* diagnoses can be obtained across some cultures with adequate and accurate information.

Sue and Sue (1987) take the position that diagnosis is more culture bound. They reviewed the literature that supports the notion that Asian Americans report psychological distress in somatic terms. Sue and Sue note that *DSM-III* requires dsyphoric mood for the diagnosis of depression. This requirement would exclude many depressed Asian Americans. DSM-III-R does permit the diagnosis of major depression without report of dysphoric mood if anhedonia is present. Still, it would be quite difficult to obtain a diagnosis of major depression based solely on somatic symptoms in DSM-III-R. On the other hand, the Hamilton Rating Scale for Depression (HRSD) does include a broad range of somatic symptoms. This instrument might be better suited for the diagnosis of depression with Asian Americans. Unfortunately, it would diagnose as depressed many Asian Americans suffering from other conditions.

A proponent of universal diagnosis might argue that Asian Americans who report somatic symptoms should receive a somatoform diagnosis. Though this might eliminate the problem of diagnosis, it obscures treatment. The proper treatment for an Asian American who expresses depression through somatization might differ dramatically from the treatment of a caucasian who carries a somatoform disorder diagnosis. Since diagnosis implies treatment, this situation defeats a primary function of diagnosis.

There are similar problems with psychological assessment. Pollack and Shore (1980) obtained extremely pathological MMPI profiles on 142 Pacific Northwest Indians. Pollack and Shore contend that the MMPI cannot be used in a standard fashion with American Indians. Their data indicates that the overall elevation of the profile, rather than the combination of elevations and scale relationships, distinguish diagnostic groups. With caucasians, the relationships between the various clinical scales are often at least as important as the elevations on each scale.

Butcher, Braswell and Raney (1983) present data on 36 American Indian, 97 black and 454 white psychiatric inpatients hospitalized in Minnesota. Minority subjects were matched with whites on gender, occupational status and social class. It is important to note subjects were not matched for diagnosis.

The authors argue that their American Indians are less pathological than the black and white samples. This interpretation is less than convincing without evidence that the Indian sample is indeed less distressed than the other groups. Butcher et al. report results that conflict with their interpretation. Seven pathology related variables are examined. Only three are significantly different. On one, Indians are more distressed than Blacks. It is important to note that diagnosis was not significantly different among the ethnic groups. Further, the relationships between these seven pathology related variables (eg, diagnosis) and MMPI scores were not explored. As Greene (1987) notes, this is essential to any meaningful interpretation of ethnicity and the MMPI.

The problem becomes obvious when the diagnoses from Pollack and Shore are considered with the Butcher et al. results. The Indian MMPI means in these two studies are similar. Butcher et al. might have us apply conventional MMPI wisdom to the Pollack and Shore data. Yet Pollack and Shore's nonpsychotic Indians would be diagnosed as paranoid schizophrenic using any of a number of resources (eg, Greene, 1980; Lachar, 1974; Marks, Seeman and Haller, 1974; Graham, 1977). Relationships between test scores and symptom related variables must be explored before it will possible to use the MMPI in any meaningful way with minority clients. Unfortunately, this is a costly and complex venture. Jones and Thorne (1987) propose an alternative to empirical assessment approaches with ethnic minority clients. They argue the client's experience must be understood, that the client must be seen as a collaborator in a joint venture. Culture is one important aspect of the client's experience. In their view, empirical approaches that seek to examine the client as object often fail to obtain the relevent information.

Whether assessment is approached from a behavioral, psychoanalytic, empirical or phenomenological framework, diagnosis and assessment may be compromised if culture is not specifically addressed. At the Seattle Indian Health Board, we are in the process of developing assessment approaches that are sensitive to the variety of Native American cultures. It is expected that well trained and experienced clincians working in the context of an American Indian clinic will be able to use these assessment approaches to obtain more useful evaluations.

Treatment

After an accurate assessment has been obtained, it becomes possible to deliver adequate treatment. As Sue and Zane (1987) seem to realize, it is extremely difficult to prescribe a formula for the treatment of minority clients. Earlier efforts to detail cultural differences have not been used effectively by mental health facilities. The "cookbook" approach may have exacerbated an already difficult problem. They note the as an individual. Special attention is paid to two elements, credibility and giving. Sue and Zane describe therapy in a way that is similar in many respects to the subjective approach of Jones and Thorne (1987).

For minority clinicians who work in an agency controlled by the community served, it is relatively easy to implement these principles. Majority clinicians, in minority agencies, who seek to work with minority group members must acquire sufficient cultural knowledge to provide effective services. Westermeyer (1987) encourages the committed clinician to live for two years in the culture. The problems multiply rapidly when majority agencies seek to serve minority clients.

In majority agencies, even ethnic minority clinicians will find it difficult to provide adequate services to members of their own group. Though accessibility is often cited as the largest barrier, the structure of majority institutions is a more important obstacle. In the development of a culturally sensitive program within a majority institution, decisions must be approved by a majority administrative struture. To use an American Indian example, there are few mental health administrators who could effectively apportion scarce resources between sweats, talking circles, traditional crafts, family and individual treatment. Without the proper balance of services and programs, efficacy is compromised. Further, few administrators would know where to recruit Indians with the expertise to provide these activities. Even if a pool of applicants could be obtained, few majority administrators would be able to evaluate the candidates abilities to provide these special services.

Clinical supervision is equally complex. Sutton and Kessler (1987) found that clinical psychologists judged clients more negatively if the client was perceived to be from a lower social class. This tendency could interact with lack of knowledge about some of the more signficant differences between the many minority cultures represented in the clinic. The synergistic effect of these two factors could lead to the placement of clients in treatment that is less than optimal. Clinical supervision might also suffer, as ethnic minority supervisees struggle unsuccessfully to obtain useful comments on the therapeutic process.

Need

In King County, the minority mental health clinics are provide a wide range of specialized services to minority clients. The existence of culturally sensitive mental health services is perhaps the most important, but not the only component, in an effective minority mental health system. These services must be available in quantities sufficient to meet the community needs. The estimation of need is a difficult problem that will be discussed in this section. Several indices of need will be examined.

A very rough estimate is the time a client msut wait to receive services. In 1987, the Seattle Indian Health Board maintained a waiting list that varied from 3 to 16 weeks. Additional funds would permit the agency to hire the staff necessary to decrease the wait. Though the demand for mental health services exceeds the supply, this does not prove that the available supply is insufficient. It is possible many who request services do not really need them. Other indices of need will illuminate this issue.

Insert Table 1 and Table 2 about here

Tables 1 and 2 display data on two other potentially important indices of need. Referrals to Child and Protective Services (CPS) are made on people suspected of child abuse. It is reasonable to assume that the majority of these people are in need of mental health treatment. Involuntary treatment is another measure of need. Less extreme approaches either were not available to the client or proved ineffective. In this sense, involuntary treatment cases are an indication of need, not a measure of treatment provided.

Chi Square analyses (Edwards, 1972) reveal a clear trend. In 1986, there were significantly fewer than expected statewide CPS reports on Whites, Asians and "Others." Blacks, Native Americans, and Hispanics were reported at a higher than expected rate. In 1986, significantly fewer than expected Whites were involuntarily treated in King County. More Blacks and Hispanics were involuntarily hospitalized than expected. Similarly, fewer Whites, Asians and "Others" were investigated than expected. Significantly more Blacks and American Indians were detained but not hospitalized.

On these two indices, Whites are less likely than expected minority groups are more likely than expected to receive these services. Asians and "others" are the exceptions to this pattern. "Others" probably include some people who would be classified as White by Census criteria. Consequently, no effort will be made to interpret "other" data.

These data support the hypothesis that, in general, need is greater in minority communities than in the majority culture. Whites, with greater economic resources, are better able to obtain expensive but effective mental health services that will prevent the catastrophes that lead to intervention by the state emergency systems. Minorities must experience these catastrophes because there is an insufficient quantity of culturally sensitive mental health services available.

Are Asians really the exception to this pattern? As noted above, Sue and Sue (1987) contend that Asians are often assessed inaccurately. This could lead to fewer CPS and involuntary treatment referrals.

Though these indices are illuminating, additional information would permit a more definitive evaluation of the hypothesis presented above. Unfortunately, ethnic CPS data is only available for the entire state. The King County judicial system will begin to track ethnicity in 1988. No agency considers South Asians separate from Asians. Since South Asian cultures are quite distinct from Asian cultures, it is impossible to begin to examine need in the South Asian community until separate statistics are collected.

Utilization

The data presented above suggests ethnic minorities have a greater need for mental health resources than whites. It is also reasonable to conclude that the quantity of available culturally sensitve services is insufficient. After all, if minorities received adequate services, they would not be overrepresented in CPS and involuntary treatment cases. Yet, O'Sullivan, Peterson, Cox, and Kireby (1987) found minorities to be overrepresented in the King County mental health system. They compared the number of community mental health center clients for each ethnic group to the number of people of each ethnic group in the county. They found less whites use the community mental health system than would be expected based on the number of whites in the general population. They also found minorities used CMHCs more than would be expected based on the number of minorities in the general population (see Tables 3 and 4). This could mean that minorities do not receive an adeauate supply of culturally sensitive services, or that it is necessary to deliver an enormous quantity of good services to reduce CPS and involuntary treatment referrals. There are however several other factors that must be considered in the interpretation of the O'Sullivan et al. results.

Insert Tables 3 and 4 about here

Whites who can afford private mental health services will purchase them. This removes whites with substantial incomes from those who seek, or need, CMHC mental health services. On the other hand, relatively wealthy ethnic minorities may seek services at minority mental health agencies because it is more difficult to find culturally sensitive services in the private sector. The impact of this effect may be assessed by comparing CMHC clients with their income matched counterparts in the general population.

Insert Table 5 about here

Table 5 displays the O'Sullivan et al. data with income modifications. In the first section, clients with incomes less than $6,000 are compared to an estimate of the King County population of persons with incomes less than $5,000. Unfortunately, it is not possible to match income groups precisely because O'Sullivan et al. report incomes in catagories that are incompatible with census data catagories. Population estimates are also difficult to obtain because O'Sullivan report individual incomes instead of family or household incomes. Population estimates for the first section were obtained by finding the number of King County families for each ethnic group with incomes less than $5,000. For each ethnic group, this number was multiplied by the average number of people per King County poverty level family for that ethnic group. All population data for all three sections was obtained from Bureau of Census (1983).

The second section is comparable to the first. O' Sullivan et al. CMHC clients with incomes greater than $6,000 and less than $9,000 are compared with an estimate of King County

County families in each ethnic group is multiplied by the number of people per King County poverty level family in that ethnic group, to obtain an estimate of the number of persons in each ethnic group with incomes between $5,000 and $9,999.

Section three is comparable to the other two. The only difference is the estimate of family size. Instead of using the poverty level multiplier for each ethnic group, families in each ethnic group were multiplied by the average number of people per family with incomes less than 125% of the poverty level for that ethnic group. This is a conservative estimate, since it is likely to overestimate the number of whites in the wealthiest sample.

The data is broken into three economic groups to illustrate the impact of economics on CMHC utilization. It is important ot recognize that 69% of the CMHC clients fall into the lowest economic group. Consequently, the lowest income catagory most closely represents the CMHC utilization pattern in King County.

When income is considered, a clear trend emerges. In the lowest income group, whites are significantly overrepresented. On the other hand, all ethnic minorities except Indians, Alaska Natives and Eskimos are significantly underrepresented. In the middle income group, whites, Native Americans and Asians are overrepresented. This middle catagory may reflect the impact of a few whites who can afford to purchase services outside the CMHC system. In the highest income group, whites are underrepresented whereas all ethnic minority groups, except Hispanics, are overrepresented. This last income group may represent the impact of higher income whites who have elected to purchase mental health services outside the CMHC system. Minorities however must rely exclusively on the CMHC system for mental health services. Even in the highest income group, minorities are concentrated in the lower income catagories. These data also support the hypothesis that ethnic minority clients receive fewer mental health services, at all income levels, than whites.

Indians stand out as an exception to this trend. This seems curious, and remarkably inconsistent, since Indians have the lowest income of any ethnic group in the state. A closer look at the O'Sullivan et al. data reveals two significant problems that influence the interpretation of the results for all minority groups. First, services for whites are geographically catchmented whereas services for minorities are not. Consequently, a white person who seeks mental health services must go to the CMHC in his area. A minority group member may seek services at the majority CMHC in her area, drop out of treatment, then seek services at her minority mental health agency. In short, O'Sullivan et al. may count minority group members multiple times. Whites are counted only once. The second problem is related to the first. Minority mental health agencies may see people outside King County. Majority mental health agencies do not except clients outside the geographical catchment area. Consequently, the ethnic minority population eligible for services in King County is larger than the King County minority population. O'Sullivan et al. underestimate the minority population served.

address both issues for Indians. It is likely that similar results would be obtained if comparable analyses were conducted with other minority groups. In the last two years, the Health Board served over 15,233 patients in all departments (medical, pharmacy, optometry, dental, mental health, alcohol, nutrition, etc.) Of these patients, over 9540 were King County Native American residents. This represents 76.7% of the Indians in King County (O'Sullivan, 1986). One could argue the Seattle Indian Health Board provides some service to all Indians who seek health care services in King County. However, a more conservative estimate will be used in subsequent calculations. It will be assumed that 100% of King County Indians seeks health care services each year.

Data from the state infomration system and the Indian Health Board mental health department will be used to estimate services to King County Indians. In the calender year 1983, there were 283 referrals. This is probably a very rough estimate of counselor caseloads in 1983. Only about half of the referrals became cases. In addition, a large number of cases in 1982 continued into 1983. Unfortunately, more accurate data for 1983 is not available. Better estimates can be obtained for 1986-1987. The Washington Community Mental Health Information System (CMHIS) indicates there were 162 Indian cases active at the Seattle Indian Health Board between January 1 and December 1, 1987. 125 of these Indians were King County residents. There are discrepencies between CMHIS data and Indian Health Board statistics, but the CMHIS data will be used in an effort to keep the analyses presented here as consistent as possible with the O'Sullivan et al. data. Further, the results are essentially the same whether the data is derived from the CMHIS or the Seattle Indian Health Board Mental Health Department. If it is assumed that December is comparable to the other 12 months, a reasonsable assumption in 1987, an extrapolation of CMHIS data indicates about 136 Indian King County residents were served in 1987. If it is assumed that 100% of the King County Indian population sought some kind of health care service in 1986 and 1987, and that the Indian Health Board only provided 76.7% of these services, then 177 King County Indians sought mental health services in 1987. The income distribution of these Indians is probably similar to that reported in O'Sullivan et al. The substitution of these estimates into the O'Sullivan et al. analyses yeilds the results displayed in Table 6.

Insert Table 6 about here.

When the two confounding variables are considered, it becomes clear Indians are as underserved as other ethnic minority groups. Table 6 provides even more striking support for the hypothesis that all ethnic minority groups at all income levels receive fewer mental health services than whites. Need is greater in minority communities, in part, because fewer services are available. The stress of poverty may also contribute to the observed need. In early work on social class and psychological distress, Hollingshead and Redlich (1958) concluded that poverty causes psychological problems. The data presented here indicates that those who suffer the most economic stress receive the fewest services.

This is a problem that can be solved, if the state is willing to commit adequate economic resources and delegate responsibility to existing minority mental health agencies.

Solutions

The socio-economic status of users of other components of the state mental health system is almost certainly similar to CMHC clients. Consequently, it is possible to calculate a population based estimate of the proportion of funds that should be spent on CMHC minority mental health clinics and on minority mental health in the state. The percentage of the ethnic population in each income catagory multiplied by the percentage of all CMHC clients that fall into that income catagory, summed over all income catagories, provides a very rough of the ethnic population served by the CMHC system. That figure is 26.1%. The governor of Washington (Gardner, 1986) proposed a mental health budget of $326,233,837 for the 1987-1989 bienium. The proposed 1987-1988 CMHC budget is $41,499,709. For 1988-1989, the governor hopes to provide CMHCs with $42,962,634. An income/population based distribution of funds would place over $85 million in ethnic minority mental health for the bienium. The formula above indicates nearly $11 million should be committed to the ethnic community mental health clinics in Washington State this year. Though the state provides substantial funds to agencies that serve minority group members, a comparatively small proportion of funds is made available to agencies established and operated by the ethnic groups served. Since ethnic agencies are the ones that can provide the most effective services to minority clients, a stronger committment to these agencies should improve service delivery significantly.

It is important to recognize the figures cited underestimate the actual percentage of funds that should be committed, if effective minority mental health services are to be delivered. Minority mental health agencies must bear all the costs of majority clinics in addition to a variety of unique expenses. Minority clinics must tailor psychotherapeutic services to the community served, include a therapeutic cultural component, and chart new therapeutic waters. Adaptations of the reverse sort are also requried. Minority agencies must meet the demands of majority accreditation agencies, auditors, and funding sources. These costs are just as high for agencies that serve the smaller minority groups, like the Seattle Indian Health Board.

A significant increase in funding to minority mental health agencies is necessary, but not sufficient, to ensure the delivery of adequate mental health services to ethnic minority clients. The state and county must also grant greater freedom to minority agencies. These agencies, with their unique expertise, are in the best position to develop and deliver the most effective services. When the state requires that minority agencies meet gaols that were developed for the majority, severe problems can arise. A goal may be set that is meaningless to some minority communities. For example, service to the "chronically mentally ill" is a worthy priority for the state. The concept however may not apply to several ethnic communities. There may not be a group of people who meet the intent of the term, yet there may be significant problems that demand intervention. Case management is an essential component of services to the chronically mentally ill. For the crucial psychological problems of some minority communities, individual psychotherapy, family services, alcohol treatment or some innovative treatment approach may be more cost efficient and treatment effective.

At present, the state and counties apply the same majority priorities to minority communities. Even those who beleive there is a universal set of psychological diagnoses contend that the frequency of conditions varies tremendously across cultures (eg, Westermeyer, 1987). It is curious that governments recognize that minority mental health treatment differs from majority approaches, but that these same governments do not recognize that minority needs, goals, priorities, and strategies may also differ from the majority. Perhaps ethnic minority mental health agencies could be charged with developing their own priorities, service goals, and community strategies. If governments are concerned that minority agencies will run wild, comfort may be taken in the knowledge that health care agencies have Boards of Directors who are sensitive both to the cultures served and the professionals who deliver the services.

The mental health problems of the minorities in Washington state are soluble. Governments need only fund adequately minority mental health agencies, established and supported by the communities these clinics serve, and allow these agencies the freedom necessary to solve the problems of their communities.

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Table 1

Washington State Child and Protective Service Referrals in 1986

	CPS cases	Estimated number of cases	Population (%)	Chi Square
Caucasian	61%	26,076	3,777,296 (88.9)	272.4**
Black	6%	2,565	105,544 (2.5)	3784.5**
Hispanic	3%	1,282	119,986 (2.8)	152.0**
Asian	1%	427	102,503 (2.4)	159.8**
Native American	4%	1,710	60,771 (1.4)	3461.6**
Other minority	1%	427	84,049 (2.0)	76.5**
South Asians	Not Reported		Not possible to analyze	
Unspecified	23%	9,832	Not included in analysis	
Total		42,747 referrals		

Note. CPS statistics from Patterson (1987). Only percentages and total number of referrals are reported. Number of cases for each ethnic group are estimated based on the two pieces of supplied data. Chi Square analyses use this estimate as the observed frequency and state census data (Bureau of Census, 1983) for the expected. The unspecified group was excluded from analysis. * $p < .05$; ** $p < .01$.

Table 2

A Sample of 1986 King County Involuntary Treatment Services

	(% Co. pop.)	Filed (% of filed)	Chi Square	Unfiled (% unfiled)	Chi Square
Asian	(4.6)	36 (3.6)	2.2	48 (3.0)	9.1**
Black	(4.4)	141 (14.0)	213.8**	171 (10.6)	140.8**
White	(86.3)	775 (76.9)	10.4**	983 (60.9)	120.7**
Native American	(1.0)	14 (1.4)	1.6	32 (2.0)	16.0**
Spanish Heritage	(2.1)	11 (1.1)	4.8*	25 (1.5)	2.4
Other	(1.6)	11 (1.1)	1.6	6 (0.4)	15.4**
Unknown		20 (2.0)		349 (21.6)	
South Asian		Not Reported		Not Reported	

Note. Filed indicates the client was involuntarily committed. Unfiled cases are investigated but not committed. Data is collected only four months of 1986: January, April, July and October. Data from Involuntary Treatment Services (1987). Chi Square analyses were performed using the above observed frequencies, and the expected frequencies reported in O'Sullivan et al. (1987).

Table 3

O'Sullivan et al. Data on Utilization Patterns in King County

	Clients in 20 CMHCs		County Population	
Group	n	%	n	%
White	10,267	74.5***	1,095,380	86.3
Black	1,356	9.8***	55,950	4.4
Native American	594	4.3***	12,437	1.0
Hispanic	262	1.9	26,631	2.1
Asian-American	742	5.4	58,712	4.6
Other	559	4.1	20,639	1.6
Total	13,780		1,269,749	

Note. CMHCs = Community Mental Health Centers.

Clients were compared with the county population.

While data are reported as percentages, chi-squares on frequencies were used for all comparisons.

*** $p < .001$.

Table 4

O'Sullivan et al. Income Data on Subjects

	White	Black	Native American	Hispanic	Asian
Monthly Income					
None	27.4	30.5	26.9	33.3	33.2
Below $100	4.1	3.4	2.6	.4	1.4
$100-249	6.5	7.4	3.8	3.1	3.6
$250-499	32.9	38.3	34.9	34.9	28.0
$500-749	9.4	9.9	10.4	13.6	13.6
$750-999	5.3	3.4	7.3	3.9	6.1
$1000 or more	14.4	7.0	14.2	10.9	14.2

Note. Numbers indicate percent of clients in each income catagory.

Table 5

Reanalysis of O'Sullivan et al. with clients matched for income

	CMHC Cases with Income ($6,000 (%)		Population Income ($5,000 (%)		Chi Square
White	7,279	(77.1)	29,450	(69.0)	89.6**
Black	1,079	(11.4)	5,661	(13.3)	24.9**
Native American	405	(4.3)	1,339	(3.3)	27.7**
Asian	491	(5.2)	4,347	(10.2)	231.3**
Hispanic	188	(2.0)	1,791	(4.2)	110.0**
South Asian	Not Reported				

	CMHC Cases with Income $6,000-$8,999 (%)		Population Income 5,000-$9,999 (%)		Chi Square
White	965	(74.4)	67,294	(79.7)	4.6*
Black	134	(10.3)	8,631	(10.2)	.3
Native American	62	(4.8)	1,930	(2.3)	34.1**
Asian	101	(7.8)	4,409	(5.2)	16.0**
Hispanic	36	(2.8)	2,167	(2.6)	.1
South Asian	Not Reported				

	CMHC Cases with Income) $9,000 (%)		Population Income) $10,000 (%)		Chi Square
White	2023	(81.5)	795,181	(89.2)	16.5**
Black	141	(5.7)	29,696	(3.3)	42.4**
Native American	128	(5.2)	7,664	(.9)	510.7**
Asian	151	(6.1)	45,258	(5.1)	4.5*
Hispanic	39	(1.6)	13,920	(1.6)	.03
South Asian	Not Reported				

Note. Population estimates based on Bureau of Census (1983).

Table 6

Reanalysis of O'Sullivan et al. Indian data using statistics from the Seattle Indian Health Board and Washington CMHIS.

Estimated Number of Indian Clients at Each Income Level	Expected Number of Clients	Chi Square
<$6,000		
121	302	108.5**
$6,000 - $9,000		
18	29	4.2*
>$9,000		
38	22	11.6**

Note. * p<.05; ** p<.01.

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

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September 12, 1989

In my remarks to you today I am speaking for Myra Munson, Commissioner of the State of Alaska Department of Health and Social Services. My name is Susan Soule. I work as Coordinator of Rural and Native Services in the Department's Division of Mental Health and Developmental Disabilities. We thank you for the opportunity to address this committee.

I will not dwell on the problems experienced by Alaska Natives. This committee has received ample testimony regarding those problems and Senator Inouye visited Alaska and talked with Alaskans. Rather, I will describe the ways in which the Department of Health and Social Services has begun to work in partnership with the villages of Alaska to encourage the development of community-based programs to address the problems, and of the ways in which the response to this cooperative effort from villages, professional service providers and state government, provides strong evidence that community-based programs can be very successful.

Two of the words I just used need to be emphasized. One is partnership. The other is community-based. The kind of partnership I mean grows out of mutual respect. It is free of paternalism. It does not give lip service to the value of Native healing traditions while, through regulations or funding requirements, insisting on techniques and approaches based on the culture and methodology of the funding agency.

Community-based does not, as we use the term, mean providing clinical services in local communities. It is not synonymous with de-institutionalization. Rather it means that local communities, villages, build the kinds of services and programs they want, based on their own assessment of local needs and problems. Agencies and mental health professionals provide support and assistance only as the communities request.

What we are discovering is that where government, professional service providers and villages work as partners and where the villages can shape the kinds of programs that make sense to them, we can have the best of two worlds, creative, effective combinations of traditional Native healing techniques and Western clinical practice.

I offer the following examples. Kake, a village in southeastern Alaska, after completing its own needs assessment, is developing a two-pronged approach to improving the mental health of its residents. It is building a program to increase knowledge of and pride in traditional culture and strengthen communications among the generations, and it is designing and delivering individualized case management services to its most troubled.

A similar needs assessment has just been completed by two villages in northwest Alaska and I recently took part in a meeting in which village people shared their needs assessment findings with regional, non-Native, mental health professionals. In response to the statement that unresolved grief was identified as a major source of stress and depression, the professionals asked how they could support the non-clinically oriented methods the assessment identified as promoting healing. The villagers asked in turn about situations in which medication might prove helpful. Tentative plans, subject to village and Elder council approval, were estabished for working together.

Our most major effort to build partnerships for community-based programs is our Community-Based Suicide Prevention Program. Now in its second year, this program funds 55 village projects dedicated to reducing the incidence of self-destructive behavior. The program developed out of the findings and recommendations of the Alaska Senate Special Committee on Suicide Prevention. Those recommendations call for creating a program that empowers the villages of Alaska to define for themselves the causes of self-destructive behavior and to develop and implement their own solutions. The recommendations ask state government to put aside its tendency to fragment services and instead encourage integrated efforts that correspond to the complex, inter-related causes of self-destructive behavior noted in the committee's report.

This program has stimulated a tremendous amount of positive energy in the participating villages. An evaluation of the first year of the program showed that volunteerism and locally raised funds contributed 48 cents for every state dollar invested. When asked what additional assistance the Department needed to offer, local project coordinators responded, "give us more information about resources available for training and education."

Most of the local projects are combining activities which bring youth and Elders together to learn and teach traditional skills with support groups, crisis response teams and training of village counselors. Most of the local projects have chosen to involve existing agencies and services providers, reaching out to school districts, regional health corporations and local governments.

The villages have also begun to work together to sponsor regional workshops, pooling funds to hire professional mental health and substance abuse practitioners to conduct trainings. For three days earlier this week project staff from Huslia, Kaltag, Nulatto and Ruby met with service providers from the Tanana Chiefs Conference to learn about helping skills and crisis intervention techniques. Staff from Alakanuk, Emmonak, Kotlik, Marshall and St. Marys, villages in the Yukon-Kuskokwim Delta, meet regularly and have conducted several workshops which combine learning new counseling skills with a celebration of traditional culture.

Our experience with the Community-Based Suicide Prevention program and other community-based mental health initiatives leads us to strongly support Senate Bill 1270. Not only do Native Americans need the opportunity to develop community-based mental health programs, but there are several elements in the bill that stand out as particularly strong. It recognizes the need to integrate mental health and substance abuse treatment in Native communities. It encourages the combining of the Western, clinical approaches with traditional culturally based methods of treatment, and it has specific provisions for technical assistance and the sharing of information.

When the time comes to implement the Indian Mental Health Demonstration Grant Program, our experience in Alaska leads us to ask you to insure that the following elements be considered. Mechanisms should be developed to inform Alaskan villages about the program. A notice in the Federal Register is not enough. The Department of Health and Social Services would be pleased to assist in this.

We ask also that the request for proposals be clearly written in non-technical language. Complex demands stated in bureaucratic or/and professional jargon discourage community-based proposals.

Finally, and of most importance, we ask that this grant program focus not on funding programs which provide services FOR Alaska Natives and American Indians. To provide a service FOR someone else is to impugn their ability to do for themselves. Rather, we ask that you fund efforts in which people, tribes, villages provide for themselves and define for themselves how best to do so. Do not impose particular methods of treatment, but establish the climate of trust, respect and commonality of purpose in which partnerships flourish and in which the best of both worlds can emerge.